
ARTISS SYMPOSIUM 2016

Understanding the Patients' Experiences: Beyond Diagnostic Labels

SPONSORED BY

Department of Psychiatry, Walter Reed National Military Medical Center

Center for the Study of Traumatic Stress
Department of Psychiatry, Uniformed Services University



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From the Conference Series:

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**Understanding the Patients' Experiences:
Beyond Diagnostic Labels**

Editor's Note: This transcript has been edited, however, as in most transcripts some errors may have been missed. The editors are responsible for any errors of content or editing that remain.

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First Edition



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History of the Artiss Symposium

Kenneth L. Artiss (1913–2001), the namesake of this symposium, was an Army officer, a research psychiatrist and instructor at Walter Reed Army Medical Center. Dr. Artiss, who served for 21 years in the Army Medical Corps retired in 1964 as a Lieutenant Colonel. He was Chief of the Department of Psychiatry in the Division of Neuropsychiatry at Walter Reed's Institute of Research. His work included development of treatment methods for combatants with severe psychiatric disorders.

After his retirement from the Army, Dr. Artiss was a senior consultant for many years to Walter Reed's psychiatric residency training program. Dr. Artiss created an award in 1983 to spur military psychiatry residents to conduct high quality research. This award still exists today and was presented at the conclusion of this symposium.

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Introduction: Beyond the Diagnosis

Harold J. Wain, PhD

Why did we choose the topic, *Beyond the Diagnosis*? Why do people respond differently to a diagnosis? We want to ask that question. Why is an algorithmic approach not efficacious for all? Why is non-compliance so readily observed in our patients, and what do we do with it?

Recently, I heard a story from one of my grandchild's classes that illustrates an important point. The teacher asked each child to draw a picture, and the teacher walked by and asked, "Who are you drawing a picture of?" The child looked up and said, "I'm drawing a picture of God." The teacher looked at him and said, "You know, that's strange. Nobody knows what God looks like." And without blinking an eye, the child looked up and said, "At the end of this picture, everyone will know what God looks like."

I am hoping by the end of this seminar that all of us will know why a diagnosis by itself is not sufficient because we need to look *beyond the diagnosis*. We want to go beyond what the obvious looks like in terms of trying to understand another person. How do we make an effective intervention with complex patients that both the patient and other clinicians understand? The answer to that question is a major goal.

What is a diagnosis? It is a shorthand attempt to communicate information from one clinician to another. When a diagnosis is used, it can simply be an abstraction. And if used by itself, rather than with an understanding of the patient, to plan an intervention, it is like planning a construction project using a map without taking into account what was used in surveying the actual ground.

Evidence-based interventions frequently go awry because the unique factors of the individual were either disregarded, not seen, or not heard. When treatment fails, the patient is labeled refractory or resistant. We never look at ourselves. It becomes the patient's fault. It is easy. We can blame everybody but ourselves for not going deeper.

What is the purpose of symptoms? Frederick Toews taught us that the

symptoms of disease are marked by purpose, and the purpose is beneficial. The processes of disease aim not at the destruction of life, but to save it. It is a very interesting comment because we develop a symptom as a protection. When we have pain, the pain leads us to seek help. When we have a fever it is a warning sign that something wrong. When that symptom is a cluster of behaviors, it serves to prevent internal annihilation.

Why do people think about suicide? What are they running from internally? What is the conflict going on internally and why does that impulsive decision occur? What do we have to do with it? A patient on the ward right now was admitted with suicidal ideation, got leave on a pass and came back with a knife. What was his thinking about his behavior? Why does he want to run from the fact that he cannot reach his narcissistic goal? What is it about his relationship with his new wife that is causing the problem? Why does he promise everyone that he is safe to leave when he is not safe? What might the symptoms be masking? What is the suicide attempt masking? That is what we want to find out.

Carl Jung coined the term “persona” and I like this word for describing what we all deal with. Persona is the appearance we present to the world. There is a character we assume through it and a way we relate to others. Persona includes our various roles, the kind of clothes we wear, individual styles, and how we express ourselves, both in health and in sickness. Why does somebody play a sick role? Why does somebody assume the depressed role or the anxious role? What are they doing with that? What is the mask we wear? We have learned by many games of charades and by the models in modern technology. We model after the roles actors portray in movies and after some of the characters in the video games that children play today.

If this were an internal medicine group instead of a group primarily of psychiatrists, I would ask you this question, “When is shoulder pain only shoulder pain?” Pain in the right shoulder may suggest gallbladder issues. Pain in the left shoulder may reflect coronary thrombosis. The function of much of psychopathology is to distort or deny either internal or external conflict. I believe it is a way of coping with internalized conflict.

Why do individuals respond differently? Some of you may remember the fascinating paper that George Murray wrote on limbic music; the paper was discussed in the late 70s and early 80s. It described how Murray saw the limbic system and how the amygdala was involved. We are talking about biological entities and how these entities operate in terms of determining behavior.

What about cultural backgrounds? What about the previous history of the patient? What about going through developmental milestones and models people have? Many of you throw out the term “unconscious.” I do not. I still look at the Freudian concepts and the Jungian conceptualization of

what the unconscious really means. Is there a collective unconscious?

What about the patient's assets? How do we encourage our amputees or our wounded to bind to their assets so they can overcome their adversities? I heard an interesting story this weekend from one of our peer visitors. This man lost his leg in Vietnam and afterwards he was in a body cast. He was sent to Japan where, unfortunately, he got gangrenous. He was at the old Walter Reed for a year. He was an athlete in college, and he said to himself, "I'll never run again. I'll never be able to do anything again." About a month later, he heard a voice within himself, and the voice said, "Jack, you were never a good athlete anyway, so what's the big deal?" He recognized that he had other things to do and that he could do other things. He could overcome. He had assets. He used his intelligence and he moved forward, and became a judge after his Vietnam ordeal.

What about the Freudian, Ericksonian, and Piagetian developmental models? I do not want to throw them out. Many people throw them out and do not pay attention to them. I think we need to pay attention. We need to see how people navigate developmental milestones in their lives.

George Engel coined the term "biopsychosocial," taking into account the biological, psychological, and social aspects. These include our defense mechanisms, personality style, coping style, and all the ways they are adapting. Part of this comes from George Vaillant, whom I respect immensely. He did a great deal of work looking at understanding defense mechanisms. Defense mechanisms mitigate the distressing effects of both emotion and cognitive dissonance. They are unconscious or otherwise involuntary. They may be discrete from one another. Although they are often hallmarks of major psychiatric syndromes, they are dynamic and, unlike the brain disease they mimic, they are reversible and modifiable. Defense mechanisms can be adaptive, even creative, as well as pathological. If, to the user, defenses are invisible, to the observer defenses appear odd, even annoying.

I will not discuss all the types of defense mechanisms. We all know them, but some are worth mentioning. What about histrionics? Colleagues hear that word and run away and never treat these patients. I prefer using the term "dramatic" because it is more benign and some of these patients may need treatment. Rather than using schizoid, I would rather use the word "reclusive." When people in medicine and surgery see a psychiatric diagnosis, they tend to run. We also know we have many patients in our ward right now who are manipulative and they violate norms.

It was Socrates who said, "The unexamined life is not worth living." What we really have to do with all of our patients is perform something like an audit. We have to at least have a therapeutic alliance with our patients, rather than the non-therapeutic alliance that the auditors have.

Julius Cohnheim, a Viennese hematologist, stated, "Clinicians must learn

to perceive a patient's often irritating, even disgusting defenses as lifesaving, as they learn to perceive disgusting pus as laudable." We have to learn to tolerate the patient's negative transference, positive transference, and erotic transferences. We have to tolerate our own counter transference towards the patient even when we have very difficult patients.

We must to learn to listen. One of our distinguished speakers will talk about the idea of listening. We have to observe the unobservable, and we have to develop a therapeutic alliance with the patient. Without the therapeutic alliance, we can use every technique we know, every scheme we know, but without the therapeutic alliance very few things are going to work.

There is an interesting metaphor that involves a patient with vocal cord dyskinesia (VCD). The patient put her hand around her throat, and the basic idea is that this is a patient who thought she was choking her whole life. She was being abused and she could not talk about it. Some of you, in the past, may have seen VCD as a conversion disorder. I look at it as an anxiety disorder because there are physical changes that occur that can be measured by laryngoscopy.

Another patient was in a coma for more than three months. One of our neurosurgeons in theater, Rocco Armonda, saved her life and brought her back here and, eventually, she awakened and we treated her. She later went to the VA and she began having seizures. When doctors looked at her scan, they were sure it was an epileptiform seizure. Dr. Armonda was not sure about that diagnosis, so he brought her back here and we were able to evaluate her. We learned she was a woman who was sexually abused as a child, and after she moved in with her boyfriend she discovered he was a philanderer. That is when she developed non-epileptiform seizures as a way of coping with some of the issues she had as a child. We were able to work with her. She is now a social worker and no longer has non-epileptiform seizures.

What are our goals? Our goals are focused on how to understand and tolerate resistance for the entire patient setting and how to deal with non-compliance. When we deal with that, how do we go back to square two, and not square one? We have to recognize what is underneath the diagnosis and what might be missing. How can we develop better treatment plans based on the uniqueness of the individual? How can we tolerate our own transference and annoyance with the patient and then develop a therapeutic alliance with the patient?

Today we have speakers who will educate us and answer these questions. We have a long day in front of us so I will conclude my introduction to a wonderful day of symposium.

Listening Beyond the Diagnosis

Russell B. Carr, MD

I appreciate Dr. Wain's introduction and I would like to add that I am also a psychoanalyst. I mention that because a great deal of what I will talk about comes out of psychoanalytic understanding. Many of the references come from that understanding and from a few of my mentors.

Dr. Wain and I agree that a fundamental piece of being a mental health provider is the process that moves us beyond a basic diagnosis and what separates us, in my opinion, from other providers. We have the privilege to strive to truly understand our patients and their subjective experience of the world. We do that through listening. I am going to talk about some key listening skills, some blocks to effective listening, and some attitudes that I feel are important. Again, a great deal of my talk is drawn from contemporary psychoanalytic writings.

What is listening? I was fortunate enough to update the first chapter in the fourth edition of the *Textbook of Psychiatry*. Dr. Mohl, who is head of consultation liaison at University of Texas Southwestern Medical Center, wrote most of it and I would like to share a quote that was mostly his. "One comes to know by listening with imagination and curiosity, allowing the words of the patient to resonate with one's own experiences or with what one has come to know through hearing with imagination the stories of others or listening to the thoughts or insights of supervisors." There is a great deal contained in that quote, and I want to try to unpack it and talk about the details today. Good listening and an attitude of curiosity are the most fundamental things I hope you take away from this talk.

First of all, why listen? It sounds like a strange question, but I can tell you in an age of growing technology some will argue that one day we will have a scan that will tell us what is going on with our patients. I argue that we will never truly understand our patients to that degree. Technology is one important aspect and can be useful, but really understanding our patient's experience is also a key part of treating them.

Those of us in behavioral health are the experts in establishing the therapeutic alliance. Listening and understanding someone is essential to devel-

oping a rapport and developing a therapeutic alliance. We are often asked by our colleagues to connect with, to help intervene with, or help communicate with patients who, because of the nature of their diagnosis, cannot connect with others very well. It could be they have a personality disorder, an Axis I disorder, years of trauma, years of their reality being denied, or any of these things.

One of my greatest mentors in my psychoanalytic training, George Atwood, is a contemporary writer. He writes from an intersubjective perspective, one of the contemporary psychoanalytic perspectives. He once said to me that nothing is more powerful than being understood by another human being. I challenge you to sit and think about that statement and dwell on it for a little while. I strive to work that way with my patients. I work to try and understand my patients. It is important for me to understand my patients and for them to feel understood, which is a key component. Good listening is a therapeutic process as well.

What are the requirements of good listening? First, you need to have sensitivity to the storyteller. Respecting and listening to patients, wanting to understand their story, and wanting to hear their perspective are key components. This is not an either/or with diagnosis or listening. The two must be considered together since listening can help gain a disease focus. It is how we diagnose. Listening is collecting data and also beginning a journey to learn who our patients are and learning about their experiences.

What are some of the tools we can use? Asking, clarifying, and testing your ideas are tools to better understanding. When I talk to residents or teach residents, I always have a hypothesis or some sort of idea in my mind about what is going on with a patient. I clarify my hypothesis with the patient by asking them questions. I always strive to understand their emotional experience. This is a very collaborative experience. Perhaps I am wrong when I am suggesting something to a patient. Being wrong can be good because I want the patient to say, "Yes, that's close but...", and then they add a little bit more and we reach a deeper understanding. This process takes a great deal of patience and hard work. Listening can also be very tiring. You might not think that listening to a patient would be difficult. Actually, I think it should be very hard. There should be multiple layers going on at the same time, both internally with your experience, what is going on with the patient, your words, their words, and non-verbal language.

What is hearing versus listening? Hearing, obviously, is the biological process that happens with our ears. Listening involves more than that because listening also involves vision. It involves our whole being, how we experience patient's patterns in their life, how we experience the patient, how patients experience us, and how that impacts them.

Because of my interest in literature and my interest in reading fiction I fo-

cus on words a great deal, including the words that patients use, and I think that is very important. As you work more with patients, you get a sense of what is idiosyncratic to them. Whenever I am listening, I am thinking about how patients use words and assessing whether a word is used in an unusual way. When I do not quite follow what I think a patient is trying to say, I ask for clarification. Many times that opens up other worlds of a patient's experience that I did not know were there.

I also hear the patient's tone of voice trying to understand a patient's associations and how what patients are saying connects each sentence to the next. One of the keys to listening well is recognizing that listening is both content and process. I hear what the patient says, how the patient is saying it, and assessing why the patient is saying that to me now. It is very important for residents to notice body language as well. I want you to notice facial expressions and what they mean. You must look at body language in a context within the patient's life, and in a context within your immediate interactions with the patient.

What does a patient omit? I often listen not just to a patient's words, but what patients are not saying. What is the patient sidestepping during a conversation? The patient was about to say something about a specific event that you suspect might have been traumatic and suddenly the language becomes superficial or hesitating. You can tell the patient is filtering what they are saying. It is important to recognize, not necessarily to bring it up to them, but to understand and try to fit it in patterns that you understand of them.

Another important part of listening is attending to your own internal reactions. Dr. Wain brought up countertransference and why it is important to understand that the observer always affects the observed. How are we impacting the patient? What are we bringing into the room and how are we responding to the patient? How does that impact our understanding of our patients? That is what countertransference really is, our patterns of experiencing ourselves and how that impacts patients.

What are some blocks to effective listening? Obviously we have differences in perspective. People say, "Oh, well, I cannot understand that perspective." I argue and others will argue that it is just as dangerous to think you understand a patient's perspective. This comes up a great deal when we are talking about deployments. Perhaps active duty psychologists, psychiatrists, or social workers have deployed at a similar time to the same part of Iraq or the same part of Afghanistan, and they assume they know a soldier or a Marine's experience. But, everyone's experience is unique so that thinking is as much of a trap as not being able to understand because of differences.

External forces that affect listening are the day-to-day stressors, perhaps other patients that you just saw or you know you are about to see. We all have

things we are supposed to be doing during the day. Another area unique to the military are commands. How do we treat and advocate for a patient while we are thinking about duty status and thinking we know the command is very concerned about the soldier or Marine that we are seeing?

Attitudes are very important. You might be having a bad day, you might be tired, or you might have a need to fix this particular patient. If you are trying to jump in and fix something for them or get away from them this can impede listening.

I want to talk briefly about listening to yourself in order to better listen to your patients. Before I began analytic training, I did not understand how being in your own therapy or analysis can be helpful to listening. I think the best way to put it is you know what it is like to be heard. You know what it is like from the perspective as a patient, but you also know what it feels like for you and it gives you a sense of what it might be for other people. You also know how we learn from our own analysts and therapists. It helps you recognize, too, your own lens and your own perspective. So much of this process is about our perspective and what we bring to the table as we strive to understand another person's perspective.

Finally, it is important to process what you and your patient talk about. We do this when we write out a psychosocial assessment or a biopsychosocial assessment. It is also important that we, at times, hold patients in mind or think about them from time to time. It helps us process. This step is often overlooked, but it is very important.

In effective listening control and power are shared in the interview. The physician is not trying to go through a checklist. You are trying to understand the patient and, during the process, it is okay to be confused and not quite certain about yourself and what is happening. Feeling like you have some objective truth and knowledge about your patient is frequently not as simple as it looks and can sometimes be deceptive. I would argue that you need to focus on understanding the patient's inner experience.

The spirit of curiosity is probably the most important thing to take away from my talk today. Listen to yourself and understand that everything that you hear has been modified by your patient's filters, and everything that you hear has been modified by your own filters. Most importantly, there will frequently be another opportunity to hear more clearly as you get to know your patient.

Much of today's talk is geared towards our residents and interns. How much do you do these things now and what barriers do you see for yourself to be a more effective listener? What are some of the problems? What are some of the barriers? I may listen to a patient and strive to understand them differently in the emergency room than I would in an outpatient setting. Listening is an art and it requires a great deal of practice and many years to

be able to do it well. Are you willing commit to the process in order to learn how to become a better listener?

AUDIENCE PARTICIPANT: What resonated for me in your talk is that you referred to the teller as a storyteller, rather than a patient. I think it is so fundamental for us to understand that people are telling us their story. The ideas and attitudes you presented open up the scope to recognize that we need to let patients tell us their story. What we enter into our computer very often will preclude the space to tell the story.

DR. CARR: I agree. There is a great deal of overlap with narrative ideas and narrative therapy along the lines of contemporary psychoanalysis - more than you may realize. I think there is a great deal of research with trauma and disruption of narratives. For example, people who have been traumatized may not be able to tell their story effectively. A large part of what we do is help patients tell their story by putting words to their emotional experiences.

Trauma and Dissociation: Understanding and Treating the Person(s) Behind the Diagnosis

David Spiegel, MD

Dr. Wain, I know that your work meant a great deal to my father, Herbert Spiegel, and I very much admire your pioneering work bringing knowledge about hypnosis to the care of the military and to the country in general. Psychiatry and hypnosis are like a genetic illness in my family. My mother, Natalie Shainess, was a psychiatrist and psychoanalyst. My parents told me I was free to be any kind of psychiatrist I wanted to be, and I took them up on it. My late sister, Annie, was the fourth doctor in the family. She was a pediatrician, and she always said that one day my parents and I would discover we wanted to be real doctors. It has been a pleasure to join in the tradition. My father, who served in combat in World War II, felt that he learned more psychiatry in combat than he learned in his training — and his training was very good, including Harry Stack Sullivan.

I would like to continue the tradition and talk about trauma and dissociation and build on what Dr. Wain and Dr. Carr presented. Things happen when someone is traumatized that make the diagnosis just the beginning of the story and that complicate the therapeutic relationship. There are things one needs to keep in mind in trying to understand the obstacles to telling the story. One simple example is a concept called traumatic transference. When people are traumatized, they are not simply presenting their symptoms, they are expecting, in the relationship with you as the therapist, that you will traumatize them as well. To them, you are not asking about their history of trauma simply to help them feel better out of the goodness of your heart or due to good listening skills, but to make them suffer again. It is natural that people talking about traumatic experiences will re-experience them in the context of the therapy. Freud called that remembering, repeating, and working through — in that you repeat in the psychotherapeutic relationship what you went through and you need to be able to work it through.

I want to discuss memory and identity, trauma and dissociation, the neu-

ral underpinnings of these phenomena, and then what we need to do to adjust our treatment of these often hidden aspects of people as they respond to trauma. There are different components of our memory process that naturally lead to a complexity in our understanding of what patients are reporting. There are explicit memories — we remember facts and we remember events. Semantic and episodic memory is different. We remember many facts and abilities, but we have rather limited episodic memory capacity. There are also implicit memories. These are procedural memories, like riding a bicycle or typing, and they are processed mainly in the basal ganglia.

There are other implicit memories that involve classical conditioning. The cerebellum is a place where we learn somatic reactions to events. Primal emotional responses occur in the amygdala. Different parts of our brain process different aspects of our memory. The things we remember as explicit events are usually processed in the hippocampus, located in the medial temporal lobe. We know that when there is damage to the medial temporal lobe in Alzheimer's disease people may remember how to do things, but they do not remember where they learned them and they do not remember what they had for breakfast. Different parts of the brain process different aspects of memory; therefore, while we present ourselves as a whole person, those of us who are entrusted to look after people who have suffered particularly traumatic events need to recognize that putting together these elements of memory is a task that is not a given. Often you will see eruption of emotion that has little to do with the current context. That may be the amygdala component reacting to a stimulus that reminds someone of a traumatic event that does not have much to do with the actual context.

Another concept I want to discuss is dissociation. Dr. Wain mentioned that there is disconnection in the experience of the person you are treating that has, in part, to do with the different elements of the memory system that we normally smooth over and present as one common experience. An eruption of anger, fear, or sadness may disrupt the continuity of experience.

Identity integration is a task; it is not a given. Our identity is related to our memories and to our consciousness at various times. Normally, we can smooth out these relationships and present ourselves as one reasonably coherent human being. Our day-to-day identity is related to the way people respond to us and to our social perception, and that has great therapeutic power. If you, as a therapist, can sit with a patient who has been through horrible experiences for which they feel ashamed and you can treat them with respect while knowing that about them, that has healing potential. That is part of the respectful listening that Dr. Carr discussed.

Our identity is also involved in the way we move through the world, how we handle the world, and in our somatic awareness and perception. Somatic

discomfort can disrupt your social context or can inhibit your motor control. This process is complicated by traumatic experiences. Suddenly the social environment becomes dangerous rather than supportive, and it can inhibit your ability to control your motor function. It can have profound effects on your somatic awareness and your identity changes. Our usual identity is one in which we think of ourselves as being in control of ourselves and our world. We feel good when we are in control. Traumatic events do the opposite. They wrest control from us and take control over what we are doing with our bodies, and that has profound effects on our identity.

Memory disturbances are common in people who have been traumatized. We can have either intrusion of unwanted memories, like flashbacks in traumatic experiences, or avoidance, when we do not want to think about something bad that happened. We avoid reminders of traumatic events or we literally cannot consciously remember events for which we were conscious. When the stressor becomes more powerful, it tends to revisit itself in very powerful ways, like in a flashback or with nightmares. We can go to the opposite extreme and have trouble recalling events or avoid remembering those events.

Emotion, in particular, has specific effects on recall and, therefore, on how people present themselves. In general, when you are stressed you have improved memory for central details. In crime, this has been called the “weapon focus” where somebody who has been held at gun point can give you a beautiful description of the gun. However, when you ask what the assailant looked like, they have no memory of the assailant because they were so focused on the most proximate threat to them. People may miss the details, but they will get the gist of the event. They understand exactly what happened to them, but not some of the details about the event.

Traumatic amnesia commonly occurs after traumatic events. Important personal information may be lost. The part of the brain that is recording episodic memory can have difficulty reporting all of the events because of the competitive firing of the amygdala and other parts of the brain that are processing emotion. The content that cannot be retrieved is often traumatic. It is potentially reversible if it is a functional, not organic, memory problem. It may still exert an influence on cognitive function; for example, a woman who was raped in an elevator and does not remember the events can find herself unable or unwilling to go near an elevator. The information is still working but it is not consciously available for processing.

In addition, there are types of trauma that have social effects. Jennifer Freyd at the University of Oregon has written a great deal about betrayal trauma which occurs when people or institutions that a person depends upon for survival significantly violate that person’s trust or well-being. Childhood physical, emotional, or sexual abuses perpetrated by a caregiver

are examples of betrayal trauma. While the traumatic event itself gives you an unpleasant social input on your identity, memory, and consciousness, if you also feel or have reason to believe that a person or institution who has responsibilities to you is letting you down, that is betrayal trauma. That complicates things even more. Dr. Freyd provides an example of how it might be necessary to have memory problems about betrayal trauma. If you are a child who depends on a parent for survival, food, clothing, and shelter, and that person is also sexually abusing you, it is very difficult to hold those two concepts in your mind at one time if you want to survive. Often, people will have amnesia for abuse by a caretaker because they have to depend on that person to survive.

In similar ways, institutions can betray us. For example, there is currently a great deal of interest about how sexual violence is handled in universities. The president of a university was recently fired because he did not take action to investigate and handle cases of sexual abuse by members of the football team. That is institutional betrayal, meaning that the institution you expected to protect you turns out to be more interested in making money on football than in protecting some of the female students.

These types of scenarios complicate your ability to process the information. It is not just the event but the context in which the event occurred. It makes it difficult for you to trust that people working for the institution are there to help you. Are they there to help you or are they there to protect the institution? That is certainly true for all of us who work in institutional settings. It is particularly a problem in the military where people are more fully dependent on the military for their food, clothing, shelter, and careers. It means that you become a part of the institution, and patients will have feelings about you as a therapist that go far beyond anything you are actually doing as a therapist. It is important to keep that in mind when you are working with patients.

Some have been skeptical about the idea that people can actually forget obviously traumatic events that occurred; therefore, they claim that these people are making up the story of the trauma. They believe that it did not happen, and the trauma is being suggested to patients by therapists. In general, this is blatantly wrong; but, one of the pivotal studies that demonstrated the skepticism about traumatic amnesia was published by Linda Meyer Williams and colleagues in 1994. They reviewed hospital records of women who were brought to emergency rooms with evidence of physical and/or sexual abuse. They interviewed the women 15 years later and asked if they could remember any traumatic events in their life and if they were ever taken to the hospital. Thirty eight percent of this sample did not remember the indexed traumatic event, but there was no question that it happened. Another 14% said they remember it now, but there was a long period in their life when

they did not remember it. A total of 52% had dense amnesia for traumatic events that occurred.

When events are overwhelming it is not uncommon for people to have limited access to episodic memories of those events, yet the memory of the event is there somewhere and it is affecting them. This creates a context for a dissociation between their conscious experience of who they are, who their parents are, who you are as a therapist, and what actually happened. That makes listening to them and treating these people much more complicated. We are learning something about the neural systems that undergird this type of traumatic amnesia. John Gabrieli, Michael Anderson, and colleagues conducted a study of normal students at Stanford University. Gabrieli wanted to know how the Freudian concept of repression might actually work in the brain. He asked a group of students to learn a series of words and then to suppress their memory of the particular words they had been shown on a list. They found that, when suppressing memories, they had activation of the dorsolateral prefrontal cortex, which is what one might expect. There is an inhibitory effect in many aspects of the prefrontal cortex on other parts of the brain. They also found inhibition of the hippocampus, which is where episodic memories are stored and retrieved. The process worked just the way you might think it would. The frontal cortex inhibited recollection, and the hippocampus responded by saying, okay, I will take the day off and not record those memories.

A recent study published in the *Proceedures of the National Academy of Sciences* used virtual reality to alter a subject's visual perception of what their position in the room was; it was an artificially-induced depersonalization experience. There were three conditions: one where the subjects were seeing what they were actually looking at, which was the interrogator giving them words and asking them to recall them; one in which they were 180 degrees reversed, so the world seemed as if they were looking at themselves and not the interrogator; and one in which they were 30 degrees out of kilter. It was a simple depersonalization imposition on the subjects. When they were in the out-of-body position — and it did not matter whether it was 30 degrees or 180 degrees — subjects recalled less information that they had been taught during the episode. This was not trauma. It was simply a depersonalization and a derealization experience that was imposed by virtual reality. They found, again, that the salient parts of the brain you might expect to be involved in this were the prefrontal cortex and the hippocampus. There was a relationship between suppression of activity in the hippocampus and the out-of-body experience. Particularly, immediately after the event, subjects remembered much less and had less activity in their hippocampus and they were correlated.

This is interesting just as a mechanism, but if you ask people how they

experience traumatic events, they almost always have out-of-body or de-personalization or derealization experiences. Most rape victims will tell you they experienced the rape as if they were floating above the person below them and feeling sorry for what was happening to them. They do not experience it, and this is a valuable thing. You do not want to have the full sensory experience of being assaulted, being in an explosion, or being raped. In fact, survival suggests that you want to detach yourself from that as much as possible and figure out what to do. When people do that, they are also inhibiting the normal processing, encoding, and storage of memories.

We can think of dissociative defenses as an adaptive mechanism directed at maintaining control over overwhelming stress. The problem is that some people can do that too well and they continue to do it. After a trauma people need to process and work through what happened. They need to put it into perspective and stop blaming themselves irrationally for events that they could not control. If you do not think about it, you do not process it. What starts out as an adaptive defense may become a set up for the development of posttraumatic stress disorder (PTSD).

[A slide was shown of people witnessing the 9/11 attacks on New York.]

One of the interesting things is two people happened to have their hands over their mouths. We use words to help ourselves and others understand what our experience is. People may talk about trauma as speechless horror. They cannot say anything about it. They do not know what to say. That means they are already inhibiting their cognitive processing of traumatic events. It can force people to reorganize their mental and psychophysiological processes to buffer the immediate impact of the trauma, but it may make it difficult for them to work through the traumatic experiences.

Traumatic events induce separation from the environment in an attempt to prevent the full impact of the trauma, but it can disrupt beliefs about what is safe, secure, and predictable. Trauma damages our sense of self. I agree with Dr. Wain's comment that symptoms are warnings. Symptoms are a sign that there is something wrong, and they are a cry for help. Symptoms may also represent difficulty in processing information or in presenting to you, as someone trying to help them, the full impact of those traumatic events on themselves. Symptoms create a sense of lack of control over our bodies and our future. Memories can become distorted and incomplete, making it harder to work through the meaning of the trauma.

Dissociation is a common response during and acutely after trauma, but it becomes problematic if it persists longer. It is a failure of integration of memory, perception, identity, and consciousness. It is treatable with psychotherapy, but the dissociative symptoms complicate psychotherapy, so we need to think *beyond the diagnosis* to some special considerations in people who have dissociative symptoms. There is evidence that dissociation de-

clines in the days and weeks following traumatic exposure. Work from Edna Foa at the University of Pennsylvania shows that in the weeks, up through 12 weeks, after a traumatic experience dissociation tends to decline, but it does not go away. There will be a substantial minority of people who continue to have dissociative symptoms post-trauma.

Another thing to keep in mind, going *beyond the diagnosis*, is that people who have dissociative experiences, in particular, tend to be re-traumatized. That is, their defenses work a little too well. They tend to feel safer than they are. The common clinical example is wives who are repeatedly abused by their husbands. If you met the husband, you would say I do not want to get within 100 yards of this guy. He is a scary, dangerous person. Wives will keep going back and think if I only make dinner right, if I do not make him angry, if I do not say something that he does not like, I will be fine. That is not what happens. They are not going to be fine, but they are able to desensitize themselves to future danger.

During treatment it is important to make sure these patients stay safe and that they do not continue to do things that further endanger themselves. Part of the dissociation in psychotherapy can be that the patient is working nicely with you and things are going fine. They are explaining what is going on and you are helping put things together, but they continue to be victimized. That is a dissociative message to you that, thank you very much, your therapy is helpful, but I am also getting hurt by it. One of the issues in dealing with the traumatic transference is to constantly raise the issue with the subject. Is therapy helping you, or hurting you, or both? Abusers do not ask if they are hurting you. It is expectable that people who have been traumatized will feel traumatized by their therapy from time to time. If patients are doing things that make them vulnerable to being traumatized, it is your responsibility to help them protect themselves from further trauma.

A study of the Oakland/Berkeley firestorm we did some years ago found that people who were high dissociators tended to get themselves into more dangerous situations. Rather than packing up and getting out of their houses as the firestorm approached, they were making lunch, thinking about doing something else, or actually trying to cross police lines to get a closer look. I talked to one person there who said, "I felt like I was in a movie. I was trying to get back to the house to see where my teenage son was. He actually got out okay, and I was trying to calm down the officer and keep my wife calm, but I didn't feel like it was real that I was there." He was doing something that endangered his own life. These types of things can happen as people deal in a dissociative way with a traumatic experience.

There is evidence that there are functional and anatomical changes that occur with dissociation. Eric Vermetten and colleagues looked at hippocampal volume in patients with a more extreme kind of posttraumatic disso-

ciation, dissociative identity disorder (DID). This is what we used to call multiple personality disorder. Dr. Vermetten found that the DID patients had significantly smaller hippocampal and amygdala volumes than matched controls. There are many glucocorticoid receptors, particularly in the hippocampus and in the amygdala, and having constant exposure to high levels of glucocorticoids can actually damage neurons. The brain is regenerating all the time. Glial cells are constantly rebuilding it, and damage to those cells can interfere with the process of rebuilding damaged neurons in the brain and result in smaller volume, which also has an effect on memory processing.

Trauma can lead to many types of psychopathology — certainly PTSD, acute stress disorder, and adjustment disorders. Many patients with borderline personality disorder also have a trauma history with a mixture of post-traumatic and borderline personality symptoms, and dissociative identity disorder. Most of these patients have histories of severe physical and sexual abuse in childhood. When we take a trauma history we have to look *beyond the diagnosis*. Charles Nemeroff did a study of combined pharmacotherapy and psychotherapy for depression. The study initially found that the best treatment was the combination of the two. Dr. Nemeroff then broke down the population based on those who had a trauma history and those who did not. The subjects that had chronic depression with childhood trauma did far better with psychotherapy than with pharmacotherapy. The subjects who were depressed but had no trauma history did much better with pharmacotherapy than psychotherapy. A trauma history makes a big difference in treatment, even for a diagnosis that is not formally associated with trauma. There are many people who have been traumatized who are also depressed, but there are many people who are depressed who have no trauma history. Please always ask your patients about a history of trauma, which I am sure you do in the military.

I treated someone who happened to have a psychoanalysis that was widely known in the public. He said, "I was in analysis for years, and was never asked about an event that I now realize changed my entire life." He was driving with his family across the country to a family reunion. He had a domineering mother and a passive father. His father was very tired. The mother insisted they could not be late getting to the reunion, so he must keep driving. He fell asleep at the wheel. The patient's mother and his sister were killed, and he and his father were badly injured. The issue was never brought up in years of psychotherapy and he said, "I've been trying to right wrongs all my life, and I realize now what started me on that path. It was that." A history of trauma is always important.

Stress affects many parts of the brain. There is prefrontal regulation during alert non-stress conditions, but there is a constant struggle in our brains

between our prefrontal cortex that tells us to sit down, be quiet, and think, and the amygdala and the limbic system that tell us to wake up, get angry, and be fearful because this context is dangerous. Each one tends to inhibit the other. If you are really emotional, you tend to say things you probably would not say if you thought about it a little. Conversely, if you are thinking a great deal, you may be suppressing emotions. It is a constant struggle going on in the brain, and there is evidence from studies of people with PTSD of activity in the medial frontal gyrus. It is decreased when people with PTSD are told trauma scripts, so there is evidence that you have activation of deeper structures in the brain that represent emotion and memory and inhibition of frontal structures that would tend to inhibit you.

Social perception is mediated by the medial prefrontal cortex in particular. It is part of the brain that says if you do this, other people will not approve of what you are doing. It tends to be inhibitory, but if functioning in that area is inhibited you may erupt and be irritable, and even potentially violent.

I was involved in a study with Ruth Lanius and her group in Canada. The study looked at people with PTSD given script-driven imagery — imagery from their own trauma experiences. We found two types of responses. The majority had the hyperarousal response in which people were re-experiencing their traumatic events. They had decreased activity in the medial prefrontal cortex and hyperactivity in the amygdala, other limbic regions, and the insula. However, there were about 14% who had the opposite reaction to the same stimuli. They had hyperactivity in the medial prefrontal cortex and inhibition of the insula and amygdala. They over-inhibited their emotion centers, rather than under-inhibiting them as with the more common type of PTSD. The observations of the difference between two types of PTSD, frontal inhibition and limbic activation versus frontal activation and limbic inhibition, led to the inclusion of a new diagnostic subtype in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), the dissociative subtype of PTSD. These are people with all of the PTSD symptoms, plus depersonalization and/or derealization. It suggests that the treatments for these two groups are different. Exposure-based treatments work well for people with the hyperarousal type of PTSD. They do not work as well for people with the dissociative subtype. They tend to further suppress their emotional reaction, so they become re-traumatized, rather than desensitized to the trauma if given exposure-based treatment.

A group at Harvard University studied dissociation in PTSD using evidence from 25,000 respondents with PTSD in 16 countries and found that 14% had the dissociative subtype of PTSD. It was associated with higher numbers of re-experiencing symptoms, being male, and a childhood onset of PTSD. They were more likely to have been traumatized in childhood. We

know that in the military people who have a prior history of trauma exposure or PTSD are more likely to develop PTSD when exposed to traumatic events during their service. Their prior histories include separation anxiety, phobias, role impairment, and suicidality. It is, in a way, a more severe type of PTSD that also calls for different treatments. This is acknowledged in the DSM-5.

In the DSM, pathological dissociation is considered an involuntary response with subjective loss of integration of information and loss of control of processes that would normally be available to conscious awareness. They can occur in any area of psychological functioning — unbidden and unpleasant intrusions into awareness, and behavior with a loss of continuity and subjective experience, positive dissociative symptoms, or an inability to access information that should be in consciousness. We call these the negative dissociative symptoms. If you have depersonalization and/or derealization, in addition to all the other symptoms of PTSD, you qualify for a diagnosis of the dissociative subtype. It is important to recognize it because the treatment approach must be different for these individuals.

The lack of integration of memory is dissociative amnesia. How do we interact with these patients? What one needs to do is identify dissociative pathology. Richard Kluft, who has worked with people with dissociative disorders his entire career, says that dissociation is a disease of hiddenness. People are ashamed of what is happening, they are afraid, and they do not want to expose all of themselves to you because they think if they do you can only hurt them more. You need to be aware, and it may take some work to figure out whether or not people have dissociative symptoms because they will not initially necessarily present them to you. You can help people with dissociative symptoms with stabilization. Many of the treatments — in dialectical behavioral therapy and some others, especially phase-oriented treatments for dissociation and borderline personality disorder — involve teaching people how to stabilize themselves and how to self-soothe. This can be mindfulness, self-hypnosis, or other things. Self-soothing is a very important part of helping people treat themselves. I often wonder, since exposure seems to be an effective treatment for PTSD, why PTSD does not cure itself since you are re-exposing yourself to the same symptoms. You are having nightmares and flashbacks. I think the reason is the lack of control. You feel re-traumatized by the nightmares and flashbacks, whereas in good psychotherapy you are structuring the trauma in a way that allows you to experience a certain amount of control. You can self-soothe and deal with the trauma by cognitively restructuring the meaning of the event allowing you to move on. That is a very different experience. It is more than exposure.

People with dissociative symptoms need to understand their symptoms and have more than simple re-exposure to traumatic events. You need to

control the risk of re-victimization and teach them how to access and control their dissociation. Hypnosis is one method that Dr. Wain has used effectively to identify dissociative symptoms and teach people how to control dissociation. You cannot make it stop, but you can make it start. You can show people how to access their dissociative states and, therefore, begin to learn to control them. They can learn self-hypnosis to work through PTSD symptoms and facilitate integration of dissociated memories, identities, or personality states. They can work through their traumatic transference that keeps coming up — they are concerned that you are there to hurt them rather than help them. You must consolidate and stabilize gains and provide support to prevent relapse.

Marylene Cloitre conducted a study using phase-oriented treatment for treating people with dissociative components of PTSD. Patients who received a combination of the phase-oriented treatment had greater reductions in their traumatic symptoms than those who only had sub-elements and did not have the stabilization and phase-oriented aspect of treatment. Teaching people how to self-soothe and manage their dissociative symptoms significantly enhanced their ability to respond to the psychotherapy. The combination also worked better in reducing PTSD symptoms than simple exposure and support and exposure alone. In fact, for a while, subjects were getting no benefit at all. Subjects finally did get some benefit, but the improvement was much faster and more consistent when people were taught how to self-soothe and manage their emotional responses to their traumatic experiences.

Similarly, Patricia Resick and colleagues at the National Center for PTSD looked at the effect of dissociation on PTSD treatment outcome and did a dismantling study of her cognitive processing therapy. The International Society for Traumatic Stress Studies conference was held last fall in New Orleans, and one of the prominent things we agreed upon is that we have become overspecialized in our types of treatment. There are common elements across psychotherapies, and even pure exposure therapy is not pure exposure therapy. You are doing it in a relationship with a person who knows what you are going through, who cares about you, and who helps you think about yourself in a different way. That involves cognitive restructuring, not just simple desensitization. The anxiety-fear exposure model of PTSD is out of date, and we need to think about a more complex and supportive way of helping people through traumatic experiences.

Resick's study enrolled 150 women with histories of interpersonal violence. She conducted either full cognitive processing therapy with written accounts or just the written accounts alone. They measured PTSD every week and showed that the full cognitive processing therapy helped stabilize people, helped them understand what they were going through, and led to

greater and faster symptom reduction than just written accounts alone. If they just had people write down what happened to them, a type of exposure without much psychotherapeutic support, they did not do as well as when it was combined with psychotherapeutic support. The effect was greatest for those who were high in depersonalization that had the highest dissociative symptoms. If people feel numb, detached, depersonalized, or derealized, they need the benefit of this additional support. The simple diagnosis of PTSD alone is not enough. Symptoms were measured using the Multiscale Dissociation Inventory, and showed that you could produce a stable reduction in dissociative symptoms over time with the combined therapy. Dissociation decreases along with PTSD if you do the full cognitive processing therapy. The level of pre-treatment dissociation predicts the outcome of PTSD treatment, and patients had better outcomes if given the full cognitive processing treatment, especially those with high dissociative symptoms.

Dr. Wain's and my family's favorite topic is hypnosis, and how that can be helpful in dealing with these situations. Hypnosis is another of the *beyond the diagnosis* issues because you have to be hypnotizable to respond to hypnosis, and not everybody is. Hypnosis is another tool to explore with your patients. Hypnosis is a state of highly-focused attention coupled with a reduction in peripheral awareness. Hypnosis has three elements — absorption, highly-focused attention, and suggestibility. It is like looking through a telephoto lens where you see great detail, but you are less aware of the context. That is what happens to people when they enter a hypnotic state. To do that, you have to dissociate or put outside of conscious awareness things that would ordinarily be in consciousness. We all do this all the time. By now, I am sure you are having sensations in your bottoms touching the wonderful chairs you are sitting in. If that is foremost in your mind, you are free to leave now. Hopefully, you have put that awareness out of your mind in order to listen to what I am saying. We do that in a more extreme way in hypnosis. Suggestibility is the thing that scares people the most about hypnosis largely because we are social creatures. In hypnosis, it is not that you cannot refuse to do something, but you are less likely to. You are less likely to evaluate and judge. You are more likely to go along with the suggestion and that allows you to focus on the center of your experience and not judge or evaluate it.

I have just described the essence of what hypnotic experiences are like. They are analogous to the elements of memory. Absorption is similar to encoding where you focus on one thing, you store that carefully, and what you store can be dissociated. It may not be in conscious awareness, but it is there. Retrieval can involve suggestibility. Social context can stimulate you to recall things that you might not otherwise recall. We know that hypnosis can activate many regions of the brain by either activating or inhibiting regions of

the brain that are involved in sensory processing. For example, hypnosis can be effective in reducing pain.

[A slide was shown of a study using event-related potentials. One line showed a normal evoked response through a series of shocks administered to the wrist. Another line showed what happened when highly hypnotizable people were told the following: your hand is in circulating ice water; it is cold and numb, and you will not be able to experience any pain. With hypnosis we filtered the hurt out of the pain.]

From this study, we found that the P1 component disappears and the rest of the evoked responses were about half as big as they otherwise would be. You can literally shut the brain down. When you use hypnosis to help people control pain, they are not simply reacting differently to the pain. They are actually feeling less pain. We are having so much trouble with opiates today, and doctors are becoming the number one drug pushers in the United States. When there are many deaths occurring from opiate use, it behooves us to make more use of the brain as a whole to control pain. Hypnosis can be an effective way of reducing or eliminating pain.

What you say to a patient makes a big difference in what part of the brain is involved. When you hypnotize people and then administer shocks and tell them their hand is cool, tingly, and numb, you create analgesia by reducing activity in parts of the sensory cortex. If you did the same thing, but said the pain is there but it will not bother you — which is what often happens with opiates — you have analgesia, but now you have reduced activity in the dorsal anterior cingulate. The anterior cingulate is a part of the brain that tells us what to worry about. It is part of the salience network. When air traffic controllers are managing complex inbound flights, their anterior cingulate gyruses are firing away. It is telling you what to worry about. Conversely, when you turn it down you reduce pain perception. A big part of pain is a worry signal. It is a signal that there is something wrong with your body and you better get help. You can, just by changing the words, induce hypnotic analgesia either in the somatosensory cortex or the dorsal anterior cingulate.

We conducted an interesting study looking at visual perception. We identified color processing regions in the brain using position emission tomography (PET) to show where blood flow was greater in response to seeing color. Then we took some highly hypnotizable people and told them to change their perception of color — either to drain color from the color grid or add color to a black and white grid. We found that when they drained color from the color grid we saw reduced activity in the color processing regions, and when they added color to a black and white grid we saw increased activity. I call that my “believing is seeing experiment.”

All of our perceptions are a combination of memory, expectation, and raw perception. When you look at me you do not say, “I will build from scratch

an image of a man and decide that there is a man giving a lecture.” Your brain identifies the pattern and matches it with what you expect. Most of the time, that works to give us a pretty veridical image of what we have, but sometimes it can be used to distort or change the image. You can do that if you change the meaning of what you are seeing as the subjects did in the visual perception study. They saw things differently.

One important concept, and this is something else *beyond the diagnosis*, is that hypnotizability is a stable trait. Most children are hypnotizable. In fact, most 8-year-olds are in trances most of the time. If you call them in for dinner, they do not hear you. This is why work and play are not different for children. They are so totally engaged in everything they do. As we mature and develop and go through what Piaget described as developing formal operations in the brain, many of us lose our hypnotizability. By the time we are 21 years old, our hypnotizability is about what it will be throughout the rest of our lives. A study at Stanford University showed that after a 25-year interval, there is a 0.7 test/retest correlation for hypnotizability, which is better than we see for IQ over a 25-year interval. Dr. Wain and I use the hypnotic induction profile to measure hypnotizability. It takes five minutes to teach a subject about their own hypnotic ability or to identify that they do not have it, in which case you do something else in therapy.

Recently we have found differences in the brain resting state comparing high and low hypnotizable individuals. We were interested in the anterior cingulate cortex and the prefrontal cortex. We looked at three resting state networks in the brain in a group of high and low-hypnotizable individuals. At rest, the highly hypnotizable subjects had a great deal of functional connectivity between the dorsal prefrontal cortex and the anterior cingulate, which subjects in the low category did not have. These two parts of the brain at rest were functioning together, and that means that it is easier for highly hypnotizable people to not worry about what they are not paying attention to and focus on what they are paying attention to. We know there is dopamine activity involved with hypnotizability, and that there is a correlation between dopamine metabolites in the cerebral spinal fluid (CSF) in hypnotizability. Dopamine is rich in the frontal cortex, so it seems to be an important neurotransmitter involved in hypnosis. A polymorphism for the catechol-O-methyltransferase gene, which is involved in dopamine metabolism, is also associated with higher hypnotizability.

In general, you can think about the brain as an action response machine. The front part of the brain is mostly involved in action. This is our motor cortex, our speech centers, and places where we think and plan about what to do in the world. The back of our brain is the sensory processing apparatus where we process visual, auditory, olfactory, and other sensations. In general, we respond to the world with the back of our brain and we act on the world

with the front of our brain. In hypnosis, you change that. You can actually use that control ability to alter the perception of the world to modulate pain perception, visual perception, and other types of perception, and that can be adaptive. This is what people do spontaneously when they dissociate during trauma. They often do not feel pain, even though they are badly injured. They are in survival mode and detached from what is happening so that they can actually survive the trauma. During the war my father got some shrapnel in his right leg and broke his ankle. It was so hot when he tried to pull the shrapnel out that he burned his hand but he did not feel pain. He said, "You know what? I'm going to get out of this alive." At the acute time of pain you do not feel the pain. You are able to detach from it, and that is a powerful and useful tool.

We have evidence that people with PTSD tend to be more highly hypnotizable than others. For example, eight out of ten people with PTSD versus four out of ten people with schizophrenia are highly hypnotizable. Hypnotizability seems to go along with having PTSD symptoms, although not everybody with PTSD is highly hypnotizable. It also suggests that hypnosis can be a useful treatment tool. It can facilitate restructuring traumatic experiences, and it can help you re-contextualize traumatic memory and restore the integration of identity. Danny Brom and colleagues have shown that hypnosis, as a therapeutic technique, is significantly effective in treating PTSD.

There are eight principles of applying hypnotic techniques to help people work through traumatic events. We call them the eight Cs: confronting; find a condensation; confession; consolation; conscious, previously unconscious, or dissociated material; focus concentration; enhanced control; and reduced congruence. First is to confront trauma to find out what is causing or is related to the symptom, even in people who do not obviously present initially with a traumatic experience as the cause for their consultation. Second, find a condensation of a traumatic experience. You do not have to go through every miserable detail of traumatic events. I will often ask people, what was the worst part of this for you? It may not be the thing you would think would be the worst part, but for them it is.

Third, there is a period of confession. In the DSM-5, we have guilt and shame. Survivor's shame is shame that people feel after their traumatic experiences, sometimes for good reasons or sometimes they have done things that they profoundly regret. We talk a great deal now about moral injury in relation to trauma. Sometimes survivors feel shame because they were degraded or humiliated or felt that they should have been braver than they were. They feel ashamed even when you and I say there is no reason to feel ashamed. Survivors tell you things they may never have told anyone else, and they feel ashamed about it. It is important to provide professionally appropriate consolation, the fourth C, to tell people that you are very sorry this

happened. This is not a time for reserve in response but, in a professionally appropriate way, to say this is a terrible thing and I am very sorry that this happened.

Dissociative disorders involve a pathological separation, and this scheme can imply interpersonal separation as well. Because the patient is dissociated, they are keeping you away from part of themselves that they are not so in touch with. That means a certain type of necessary estrangement in the therapeutic alliance and also the concern that they may feel you are hurting them even when you are not. This complicates the traumatic transference — the need to recognize that the psychotherapy may either not be helping or may be hurting them in some ways. This is an issue that needs to be constantly brought up and discussed with patients.

Judy Herman sees families as the unseen force that is experienced by the patient in their transference to you. There may be reactive dissociation in the therapist. You may find yourself detaching and dissociating because you feel that you are not getting at the real affect of what is going on. You feel held at bay, and you may be detaching yourself from the patient.

We talked earlier about betrayal trauma. I tell my DID patients, we have to keep you safe and this means if you cannot promise me that you are not going to kill yourself, I will put you in the hospital. I will not accept as an excuse the fact that the “Mary” identity did not know what “Susie” was planning to do. That typically works pretty well. One of my patients had one of her angry identities tell me a very scary suicide plan. I said, “I’m going to have to talk with the other parts of you about this.” She said, “You can’t do that.” I said, “Oh, really? Why not?” She said, “Doctor-patient confidentiality.” I said, “I don’t think so.” She later said that she thought I held her together with crazy glue. You need to bring material into consciousness that previously was not held in consciousness, and this is the fifth C.

You do some cognitive restructuring. I often have people in hypnosis dissociate their somatic response from their psychological one, and picture on one side of the screen some element of the trauma that was terrifying and on the other side what they did to help themselves or to protect someone else. I have never met a trauma survivor who has not engaged in some strategy that is clever in protecting themselves. I treated a woman who was traumatized by an attempted rape. She fought with her assailant and he was surprised. He tried to drag her up to her apartment, and the police came. She had not actually been raped. The police left. She then had a seizure and it turned out she had a basilar skull fracture from the battle with her assailant. She blamed herself for having been hurt. I had her picture the assault on a screen, and she said, “I’m seeing something I hadn’t realized before. He doesn’t just want to rape me, he wants to kill me. If he gets me upstairs, I’m going to be dead.” I asked, “So what did you do to protect yourself?” She said, “Well, he’s sur-

prised I'm fighting that hard. He didn't expect it." She realized on the one hand it was worse than she originally thought, and on the other hand it gave her a re-structured view of what she had done. She did not get herself hurt; she saved her own life. That scenario represents the type of intense cognitive and affect restructuring you can do with techniques like hypnosis.

We used hypnosis on a 16-year-old to regress to four years old which was a time when her father was assaulting her mother and threw her across the room. Her drawings done within half an hour of one another with herself and her mother were very different. Her 4-year-old drawing had no faces and people were floating in the sky. Her 16-year-old drawing was much more serene and over controlled. Patients get into the mental state of the age that they once were and that is the essence of dissociation. You lose your broader context of how things have gone since then. It is like a flashback.

Seventh, you want to enhance control over what is happening to make patients feel in control of what they are doing. You do not do something to them, but instead you teach them how to control what they are doing. The goal is congruence, the eighth C, to be able to integrate traumatic information into their present lives and not have the need to dissociate in the way that they had previously. Hypnosis can allow for recovery and reprocessing of traumatic memories and symbolic restructuring of the traumatic experience while patients have enhanced control. People fear that hypnosis takes away control. Hypnosis actually enhances control. The goal is to pull dissociated elements together so that you are not the victim. You are the person in control of what is happening.

The dissociative psychotherapies differ from hyperarousal therapies and they add self-stabilization and control. In general, dissociation is a common and adaptive response to acute trauma. It can inhibit processing of traumatic experiences. It is a component symptom of PTSD. There is neural imaging and epidemiological evidence for the dissociative subtype and outcome is improved for this subtype with different types of psychotherapy.

I want to acknowledge our sources of grant support, including the National Institutes of Health and a number of other organizations. I will conclude with my final thought. It is my feeling that while we should have the deepest respect for reality, we should not let it control our lives.

AUDIENCE PARTICIPANT: I love your eight Cs, but I was curious why you attached that to hypnosis because it seems like those eight Cs are really the core principles of trauma-focused treatment, whether it is EMDR (Eye Movement Desensitization and Reprocessing therapy) or other types of trauma-focused treatment. These are the core components that we incorporate into those treatments.

DR. SPIEGEL: Thank you for that. Certainly, and I started this a long time ago before some of these other therapies were done. Hypnosis is not a treat-

ment. It is a state of attention, and you need to have a therapeutic structure within which you employ hypnosis. Many are principles used in many types of psychotherapy. Remember, the oldest form of hypnotic induction was the dangling watch. That is what happens to your eyes when you are doing the EMDR. You are moving the eyes in the same way. I think there is much in common with hypnosis in some of the elements of EMDR, but you are absolutely right. They are meant to be elements of good psychotherapy for trauma, but they fit very nicely with hypnosis as well.

AUDIENCE PARTICIPANT: You mentioned flashbacks before, and I know many people consider flashbacks to be a form of dissociation. I also know that when we diagnose PTSD we separate it out from depersonalization and derealization. We see many patients who have flashbacks but do not have the other two forms. What are your thoughts?

DR. SPIEGEL: Depersonalization and derealization are mainly dissociation of somatic experience or intrapsychic experience in a different way. Flashbacks are a dissociation of your current situation. You are re-living the traumatic event but not thinking about the fact that you actually survived it. In depersonalization you are just feeling detached within yourself and in derealization you are feeling detached from the world around you. They are all dissociated phenomena, but they involve different domains. In a flashback you are reliving the event by forgetting that you actually survived the event.

AUDIENCE PARTICIPANT: Would you recommend exposure therapy for flashbacks?

DR. SPIEGEL: I think you need more than just exposure therapy. You need stabilization as well. There is also amnesia in standard PTSD which is another dissociative symptom. In PTSD there are many dissociated symptoms. The more dissociation you have, the more you need these other steps like the self-soothing stabilization and control, and not simply exposure therapy.

DR. NAVARRO: Thank you, Dr. Spiegel. It makes me think of some of my experiences when I was deployed. Dr. Spiegel said you have to ask about the most traumatic experience for your patients. During my deployments, I was shot at a few times, but the most traumatic thing for me was when my brother and his wife had a set of twins. They were born at 25 weeks gestation and when I called to congratulate him, he said, "Well, don't do that because the doctor said they might die." For me, that was really the most traumatic thing, even though I had all these other things that people thought would be very distressful. It brings us back to the point that it is very important to ask people about the most traumatic thing for them.

Uncertain Footing: Practicing Beyond the Evidence Base

Stephen J. Cozza, MD

When Dr. Wain asked me to talk about a topic related to *beyond the diagnosis* I decided to focus on a personal piece, a philosophical piece, and a practical piece. I hope to communicate a deep respect for the richness of the science that contributes to our understanding about how we care for patients and also to recognize the limitations of science and how, as practitioners, we are generally required to practice beyond the evidence base. When and how do we do that?

I will begin with a story of the summer of my PGY2 year when I had 10–12 patients on the ward. Back then, the entire year was focused on challenging inpatients and it was very difficult. As more patients were coming onboard, I could not find a way to treat them effectively. One night I had a dream where I was being chased down the hall by my patients and I was throwing handfuls of medication at them. It sounds comical now, but what I felt at the time was my patients really wanted something from me and how was it that I was going to give it to them? How would I know what to give them? I was new to psychiatry. I recognized the fact that psychiatric practice was actually more difficult than surgery in many ways because of the complexity of the cases that we treated. The goal today is to understand how to practice in ways that allow us to bring our knowledge and our abilities to the patients that we treat.

I am grateful for our practice guidelines, the science and evidence base that supports the way we practice. It gives us knowledge and helps us understand how we approach certain cases in certain specific situations. Most of our practice guidelines were developed using science that was focused on very precise populations. Often patients do not fall neatly into each of our practice parameters or our practice guidelines.

We use the term “evidence-based practice,” but what seems more appropriate to me is to think about them as evidence-based procedures that give us an understanding of what works most of the time for most of the people that have a specific problem and who are seeking a particular outcome that

was studied in the evidence base. That is not always the case with the patients that we see. The challenge is that most of our patients do not fit neatly into these categories.

[A slide of a map was shown that was developed by researchers at Los Alamos National Laboratory.]

The map looked at the click streams of over a billion people using 23 databases to understand the mapping and relationship between scientific areas. What it shows us, when you look at the kinds of areas that affect our practice in psychiatry, either directly or indirectly, is that our field is broadly affected by science. Much of the science has not been related to itself, and most of the science is actually quite modal, meaning that science, because of the scientific process, focuses on developing understanding in very specific areas under very specific circumstances. Because of that there are many areas that are not covered by science. When our patients live outside specific areas, how do we approach them?

If we become proceduralists in our approach to patients by applying certain practices that we identify as evidence base, then, by definition, we are limiting the scope of the problems that we are interested in or able to address. It is expected that we will need to specialize in certain areas. If I say I do cognitive behavioral therapy (CBT) or I do psychopharmacology, I am defining myself as a proceduralist, rather than a practitioner.

How many people here today actually knew Dr. Artiss? At the time I was in residency at Walter Reed, the way many of us understood how to develop an understanding about practice was related to the work of individuals like Dr. Artiss and other mentors. It is a privilege to speak at the Artiss Symposium because I was one of Dr. Artiss' students. During our residency, we spent two to three hours a week with Dr. Artiss each year. You can imagine the amount of influence that he had on us.

Dr. Artiss was an extremely tough and demanding professor. He expected everyone to have read everything that was assigned. He was known to walk out of seminars if students were not properly prepared and would say things like, "No one is responsible for your education except yourself. Do something about it." Dr. Artiss was a journalist by training, so he scrutinized things very carefully and he scrutinized theories. He read all theories and he also was very careful not to endorse particular theories. If they fell apart, they fell apart. Most importantly, Dr. Artiss was fiercely independently-minded. He ensured that his students were similarly the same. As we think about the development of how we understand practice principles, Dr. Artiss had a great influence on many people here.

Residents were assigned many readings in his seminar. The first year seminar, the PGY2 year, was held at Walter Reed, and the PGY3 and PGY4 years were held at his home. They covered many areas and no topics or sources

of information were off limits. The papers had to stand on their own merit. If they survived scrutiny, that was great. If they did not, they were critically excoriated. The articles covered areas like psychoanalysis, developmental theory, sociology, theology, philosophy, anthropology, and history. When we studied Sigmund Freud and the invention of psychoanalysis, we also were required to study what was going on in Vienna at the time to describe the social scene, the arts, and music, because, for Dr. Artiss, context was extremely important. For example, if we had a patient who committed suicide Dr. Artiss reconstructed the seminar to focus on suicide: how we understand it, how it affects patients, and how it affects clinicians.

A reading by Martin Buber, a philosopher that we studied in Dr. Artiss' seminar, had a great impact on me. "Man wishes to be confirmed in his being by man and wishes to have a presence in the being of the other. Secretly and bashfully he watches for a yes, which allows him to be and which can only come to him from one human person to another." I think this speaks to what we can anticipate or we can expect that patients require of us. We can provide a place where patients can share their secrets, where they can be looked at objectively, where they can work with us, and where everyone is mutually respectful.

In my PGY3 year one my early psychotherapy patients came for therapy every week. She never missed a session, but she never said a word. All she would do was grunt, regardless of what I asked of her. I tried multiple approaches. I was empathic. I was reflective. I was direct. I waited. I tried using humor. One day after several months, I said, "Karen, you come every week, you're always on time, you never miss an appointment. Why do you come if you don't want to talk?" She turned to me and she said, "Dr. Cozza, you don't understand. You're the only person I talk to." After that conversation, she was able to open up and address a number of issues, and we were able to use things like medication and ongoing treatment to help her. I think this reflected her understanding that this was a place where she could be without criticism or without judging who she was. She came from a Midwestern family that was very critical of her, very critical of her siblings, and did not allow any expression that was outside the family norm.

When we think about the kind of evidence that is allowed and when we talk about scientific evidence the other thing we need to consider is what we learn from our patients and what they teach us. How can the clinician *go beyond* and help others *go beyond* gathering information about and for the patient? How can the clinician best engage with a patient as a person and use the data gathered in that relationship and other data to understand the patient and to plan an intervention? Gordon Harper, et al wrote about relational data. The idea of using data gathered in a relationship, as opposed to data gathered by looking at the patient as an object, remains a challenge. This

is true for all of us and remains a challenge. There are many ways to collect evidence for our patients, but relational data is an important one.

I work with teenagers who say the darndest things, and sometimes do not say the darndest things, or do not say anything. Zeb, 15 years old, came from a very successful affluent family. He had ADHD, learning problems, and was a very mediocre student. Both his parents were Ivy League educated. Zeb had a younger brother who was brilliant, fulfilling of his parents' aspirations as a prodigy, an athlete, and was a total social success. Zeb was seen as very easy and easygoing and his parents described him as kind of forgetful and he just did not get his work done. Often, he did not turn assignments in to his teachers.

When we were working together, Zeb shared some things with me. Remember he was being treated for ADHD and was taking medications. He actually dismantled practically every attempt for any kind of evidence-based care. Zeb chose not to take his medications and his parents would find them in the toilet. His tutors would say that he did not do the work that he was supposed to do.

One day, he came in and said, "I noticed something. I found that when I get a worksheet at school, I fold it and I leave the blank sides out and I put it in my backpack. When I go to look at it at night, I do not see it there. I do not see that the paper is there." We began talking about it, and the folded paper became a metaphor for all the things that he was choosing not to see in his life: the difficulties he was having with his brother, the difficulties he was having with his parents, his unwillingness to accept the fact that he had difficulties that they did not have, the ADHD, and his learning problems. He said, "In our family, those things are just not acceptable." There were many treatments available to help Zeb. He was blocking them because of the difficulties he was having accepting them. He was blinding himself and, therefore, could not participate effectively in his treatment.

I believe uncertainty in the clinical decision making is underrated. Clinical decision making always involves uncertainty. Even in the most evidence-based circumstances, prudent clinicians understand that individual outcomes are uncertain and that available data may or may not generalize to their patients based upon the studies that were conducted. At best, randomized control trial data allow estimation of the probability and magnitude of benefits for people similar to those who enroll in the supporting trials, and that includes the outcome measures. What do trials measure? How do they determine whether or not it was beneficial, and are outcomes aligned with what the patient wants?

In my PGY4 year I had another very difficult patient. He had dissociation, seizures, self-identity issues, depression, and anxiety. There was also a history of childhood abuse. There was a question that he might be exposing himself

to children. I turned to my supervisor and I said, "I am really confused about this case," and she said to me, "Dr. Cozza, you are not paid to be confused." I thought that was a little harsh at the time for a couple of reasons because I was not getting paid much at all. I think it was also harsh because, as physicians and clinicians, we are generally uncomfortable in accepting uncertainty or not being entirely clear about what it is that we are doing with our patients. We are taught to hide uncertainty, and that can lead to act in ways that may or may not be helpful to the patient. If we act based upon information that we do not have, then we may not act in the patient's best interest.

Considering how uncertainty in practice can add richness to our clinical understanding and treatment is worth discussing. I believe uncertainty signals case complexity. It allows us to become curious about the patient. Perhaps, more importantly, it allows us to become curious with the patient. It encourages collaboration with our peers. If a small hammer is not working, a bigger hammer is less likely to work.

Another patient I have been working with is a middle-aged woman who was treated for depression. She came from a family with an over-controlling mother and the patient had a great deal of difficulty in terms of being self actualized. She had difficulty taking care of herself. She became very dependent and very passive in her approach to her husband. We were involved in an intensive treatment that included both medication and psychotherapy, but she was getting worse. I talked with her about this and whether or not we needed to try something different. It seemed like she was struggling with the idea about working with me because it was either feeling too close or too far away. She was having difficulty figuring out how to be close to me in a way that allowed her to feel comfortable. We discussed seeking a second opinion and I referred her to a colleague who used dialectical behavior therapy, which the patient found very valuable in terms of developing skills. Eventually, within the context of two clinicians working with her, the therapy actually balanced some of the issues of transference. She was able to manage her relationship with me better, as well as the other therapist, and the outcome was much more successful.

Ricca Edmondson and Jane Pearce described clinical wisdom in the following way. "Wise reasoning is flexible, taking into account that human situations change and can be seen differently from different perspectives. Clinical wisdom is responsive to patients' predicaments, incorporating understanding of what these predicaments mean to them. It requires collaboratively defining models that help patients understand themselves." I would add that, collaboratively, clinical wisdom helps us to work with patients to make best choices based upon models that also include evidence-based procedures. Rather than doing something to the patient, it is doing something with the patient. It is helping them understand that a procedure is part of

the treatment, as opposed to being the treatment, and there is a difference between the two.

There are some harsher criticisms related to evidence-based procedures that I think are unfair. For example, John Geddes and Stuart Carney wrote that strong statements are made in the absence of sufficient evidence. At best, this disguises the continuing clinical uncertainty about practice. At worst, it may recommend a course of action that could be unhelpful, wasteful, or even harmful. Guidelines are sometimes based on outdated consensus, and this is true, I think, for the professional organizations in terms of keeping up with the guidelines they create. It is extremely concerning when the driving force for the development of implementations of guidelines is driven by financial or administrative control of practice. If we are driven to practice in a certain kind of way that undermines our capacity to treat patients, it is going to undermine our capacity to provide care.

Many of you know I am a child psychiatrist. There are a few approaches that have been helpful for me in understanding my patients, and one of those is developmental theory.

[A slide was shown of screenshots that were taken from the video that Frans Hofmeester made of his now 16-year-old daughter.]

Frans Hofmeester videotaped his daughter for 15 seconds every week from the time she was born until the time she was sixteen. You can find the video on YouTube. The screenshots are the same person, right? That is the point. They have the same name. They have the same genetic makeup, but not the same genetic expression. They might have the same temperament because that tends to be fairly durable, but maybe not. They have vastly different abilities, behaviors, and interests, and during their path of development there are continuities and discontinuities in life that we need to understand.

Why is development helpful in thinking about our patients? It is a dynamic process, and what I mean by that is, when we look at diagnoses, we are really looking at cross-sectional or phenomenological processes. We are saying this is what a person is. When we think about development, we are looking at an organism in motion resulting in change and growth, and we can observe processes and lines of development. I think of it like a single case longitudinal study. New adaptive systems emerge, and new problems emerge. The timing of those tells us a great deal about the person. There are also developmental forces that take place that push people forward that foster maturation. Younger children want to be socially involved and parents want to be good parents. It becomes a great force in terms of therapeutic effects, so it very often can align. For example, I have worked with people who have been very depressed and do not want to go on but they want to be good parents. I will take that developmental drive, and I will work with that to help them move forward and become more activated and do what they can

to be better parents for their children. Similarly, for children, I use that same drive in thinking about how to help them manage behavioral difficulties if, in fact, they are driven to be socially active and accepted. These are examples of great opportunities.

There are also developmental traumas or crises that can become triggers for future disruptions. When I went into child psychiatry, I was not sure that I wanted to work with kids. It turns out I really love kids, but I thought about child psychiatry as a developmental fellowship. Development is not just about kids. Development occurs throughout the life course, well into geriatrics.

[Two vignettes were presented that illustrate how developmental traumas became triggers for other disruptions.]

Staff Sergeant Jane Johnson was hospitalized after a suicide event following a series of work conflicts with her company first sergeant and fellow NCOs. After 12 years in service, she wanted out of the Army. Her commander was prepared to offer her an administrative discharge due to recent poor work performance.

Jane came from a single-parent family with a mother and three older brothers. She was repeatedly sexually abused by the eldest brother until he ran away from home when she was 15 years old. Her mother favored the boys in the house and never protected Jane. “I was like her, a woman. I wasn’t worth anything.” When Jane was 18 years old her eldest brother moved back into the house, creating a period of intense anxiety and depression for her. She ran away from home shortly thereafter, dropped out of school right before graduation, and lived with relatives for several years. During that time, Jane was able to find a few part-time jobs, and she earned her GED. She joined the Army and was surprised by her new sense of independence and success. She earned rank rapidly and was highly respected for her work ethic until she became a platoon sergeant in her current unit, which she perceived as threatening with a demeaning group of senior male NCOs. Jane was quickly able to see the similarities in her earlier home relationships — a desire to flee a depressing and high-anxiety situation. After recognizing the importance of her Army career, Jane was able to re-engage the commander and work a solution that included a reassignment.

Developmental disruptions and traumatic exposures in this case served to trigger the episode, and Jane recognized the need to seek further treatment. This was only a two to three-session intervention. Sometimes we think about therapy as being long-term and long-lasting, but the effects of effective intervention for our patients, especially in crisis situations, can be very helpful. Again, this was not really a diagnostically-determined situation. It was much more developmental with prior history of trauma.

Ted was a 65-year-old retired Army Lieutenant Colonel who presented

extremely depressed, seemingly due to metastatic prostate cancer that was very aggressive. Ted had tried a series of antidepressant medications that were marginally helpful. He had been involved in a CBT group for depression that he attended twice and then dropped out. In addition, he had been enrolled in a death and dying support group with his wife, Helen. Helen found it useful to talk in the group; Ted was mostly quiet.

Ted was referred for an individual assessment and, while talking, he continued to shake his head and talk about how there was so little time. When I asked him what was most pressing for him he bent and shook his head quietly and began to weep. "I always thought I had more time, so I kept putting it off." Ted shared that he had been involved in a friendly fire incident earlier in his career. He wanted to talk with his old unit mates at the time, but it never happened. "I need to get this right before I die."

By talking more about the event, Ted was eventually able to see that much of his guilt and sense of responsibility had been overinflated. After careful consideration, he decided to share the information with Helen and his eldest son, as he said, "I need someone in my family to know about this before I die." While Ted's initial diagnosis of major depressive disorder was appropriate, his symptoms resolved with the identification and treatment which really was a developmental crisis for him. It was something that he needed to resolve in his old age before he died.

I want to briefly mention family systems theory. Family systems theory is another theory that often informs work with a specific application that has been closer to home at Walter Reed over the past several years. Medical practice in this country has a very fixed focus on patient-centered care. Perhaps that has to do with the fact that science tends to be organism-driven or perhaps it has to do with insurance, which tends to focus on individual care as opposed to family care. We are social beings. As we think about where we sit, patients are in a series of concentric circles in which they are surrounded by people that either provide for them, support or help them, or they are in families where their conditions may have some impact.

Much of the work that many of us have been doing over the past few years focuses on the impact of combat-related activities on families. When we think about PTSD as a diagnosis for an individual, we also need to think about PTSD as a diagnosis with a major impact for families. PTSD results in change in behavior, personality, cognitive function, and emotional regulation. It leads to the concept of ambiguous loss where a person who was present in the family may be physically present but who is no longer emotionally present. This creates a negative impact on a variety of different things, including parenting and family functioning. It elevates family distress, contributes to violence, disrupts relationships, and causes symptoms in children as well.

Stacy was a 39-year-old U.S. Army sergeant who returned from a sec-

ond combat deployment tour to her family, which included her husband Bill and their twin nine-year-old sons. Six months after returning home from deployment and after a heated marital argument, Bill demanded that Stacy seek out mental health treatment for her escalating alcohol use and isolation at home. This is another good example how families can participate to initiate care for some of our servicemembers.

Although reluctant, Stacy eventually agreed and was seen by a psychiatrist in consultation. She endorsed a history of recurrent nightmares, flashbacks and arousal, and was given a diagnosis of PTSD and alcohol abuse. Of most concern to her, though, was the fact that she felt like she had completely lost touch with her two sons.

At the second session, Stacy allowed Bill to attend her mental health appointment. He reported that he and Stacy had always had a strong marriage until she returned from her first deployment to Iraq. Because the family was rapidly assigned after she returned, Stacy was unable to reconnect with any of her other prior unit mates and was re-deployed within nine months of her return. Since her return from the second deployment, she had been extremely isolated at home, was often verbally angry with Bill and her sons. In turn, the boys were also getting very angry and demonstrating behavioral problems. Once an active and loving mom, Stacy no longer attended any of the boys' school or sporting events. Bill also noted that she seemed uncomfortable being physically close to either the twins or to him.

In discussion with both Stacy and her husband, the psychiatrist made arrangements for a social worker to join them in a future family session that included both boys. In a variety of differently-configured parent, child, and family meetings, the two clinicians were able to help the parents explain the nature of the mother's illness to their sons in a way they could both understand. It clarified their misperceptions that she was angry with them and no longer loved them.

Great care was given to set boundaries on the degree of information that was shared. For example, as Stacy talked about her hesitancy to be close to her sons, she shared the traumatic memory of being on the scene of an improvised explosive device explosion that resulted in the deaths of several Iraqi schoolchildren. Closeness to her sons served as a trigger for that memory. Although she eventually felt comfortable sharing the information with Bill, they both agreed that such vivid details were not appropriate for their sons.

In family sessions, the social worker skillfully found opportunities to identify and draw on the family's long-standing strengths, their sense of connection and closeness, effective communication skills, and problem-solving capacity. By doing so, the family members were able to re-develop a sense of family continuity with pre-deployment life and develop a sense of

future hopefulness.

Even though Stacy still has some symptoms of PTSD she was relieved she found a way to renew family closeness. This speaks to the idea that we might think we are treating a patient for PTSD, but this patient's primary target was addressing the relationship with her children.

In conclusion, I would like to address the idea of evidence-based practice. There is an imperative to study the evidence base and understand what supports recovery of our patients from their conditions. We also need to recognize the limitations of that science, and we need to differentiate evidence-based procedures from what is a broader sense of how we practice with our patients. Many of our patients exist in what we refer to as this intergalactic space, this place where science really does not prescribe exactly what it is that they need. We need to help them. We can also gain insight through relational information. We can understand, incorporate, and learn from a sense of uncertainty and practice, and we are reminded that practice is an art, as well as a science. Attaining clinical wisdom, in and of itself, is a developmental process. Clinicians need time to do this kind of work, which is probably one of the biggest logistical issues that many providers face today.

Why Isn't a Diagnosis Deep Enough? A Perspective from Internal Medicine

Louis N. Pangaro, MD

“Doctor, help me.”

This is a simple way of expressing the relationship between physicians and patients in order for us to start a conversation about the meaning of the word “diagnosis.” Since the theme of this year’s Artiss Symposium includes *beyond the diagnosis*, there is already a sense that “diagnosis” is insufficient — that it is not adequate to describe the relationship between the physician and patient.

How a physician responds to the request, “Doctor, help me,” and how doctors are trained to respond is the general question I will address. What we think or hope that we are doing when we relate to patients, and how we train the next generation to do this, is the general background. I preface this with the remark that when discussing diagnosis today I do not propose to review the available literature on what we mean by “clinical reasoning.” Even with the hundreds of articles in the last decade on this topic, there is not a clear consensus on what we do individually when we “solve” a single case in order to make a diagnosis. What I see at this point is merely a developing vocabulary, and I will allude to this theoretical approach to clinical reasoning.

My approach to the question of what “diagnosis” means and what it implies about the relationship between the physician and the patient is linguistic. In general, my talk comes from a blend of a theory of internal medicine and what is, broadly speaking, called humanism. Humanism is a focus on the products of human beings, literature, and words as opposed to science or revelation as the best tools for reaching the meanings underneath what we think we are doing.

In the process of my talk I will make recommendations for how we teach the medical interview, how we teach writing clinical notes, and how we teach the presentation of the “History of Present Illness,” or HPI. I hope these will be useful as small-scale solutions to the problems caused by the centrality of “diagnosis” and “certitude” in the methodology of internists, as I understand

it. I will also venture into broader recommendations about how the available models for a medical school curriculum are still limited. My thoughts emerge from within a tradition and originality is not my goal. I often speak to an audience that has already thought a great deal about what I will say today, and I thank you for listening to my thoughts.

For internists, one of our most highly prized skills — the one that internists often say they love the most — is “making the right diagnosis” or figuring out the “difficult case.” Medical students who choose internal medicine as their specialty often say that this is what attracts them. In part, I will *defend* what we do when we make a diagnosis, but I will also explore its rationale and limits.

First, I will present some terminology and definitions. I hope that this brief use of etymology will be a tool for us to set up the problem of how we build up knowledge and meaning from our experience. I frequently use the word “physician” rather than “doctor.” The etymology of the word physician tells us that we are somehow committed to an understanding of “nature,” since the Greek word *physis* means nature, and is closely related to our word for physiology and physics. An understanding of what human nature is and — more importantly, in the context of today’s symposium — what is “natural” for human beings, what is normative, is *not* the subject of my talk. I simply wish to propose that if one wants to call oneself a physician, one must be committed to understanding nature. It will become clear shortly that I do not mean that nature is simply biology, anatomy, physiology, and all that we learn in the first few years of medical school. Second, I am using the word physician, but my colleagues who are nurses, psychologists, and physiotherapists are all equally committed to an understanding of human nature, whether structural, physiologic, or spiritual, and I hope not to exclude them from my discussion today.

The second term I want to discuss is “diagnosis.” It is the subject of today’s symposium and deserves an exploration. “*Gnosis*” is the Greek word for both knowledge and understanding, and “dia” means through or literally “right through” (dia-rrhea means it flows right through you). *Gnosis* is a cognate of our own word “knowledge,” the “kn” being an equivalent of “gn” in *gnosis*. I am using *gnosis* in the root sense of experiential knowledge, not mystical intuition. To pay a momentary nod to the importance of “narrative medicine” in my theme today, it is generally accepted that the “n-r” in narrative is related to the ancient concept that some knowledge or wisdom is contained in a storyline.

The importance of “diagnosis” in the world of an internist is that it is a first step in our answer to the, “Doctor, help me” question. It is the recognition or, to be fairer, the *proposition* that a mixed set of symptoms and findings with which a patient comes to a doctor when asking for help can be

the manifestation of an underlying process (and of course we prefer it to be a *single* underlying process). Internists search for a pattern in the data that forms a recognizable storyline (or what we now sometimes call an “illness script”), which allows us to make an inference to reach a provisional conclusion about what is going on with the patient in front of us. If we see that the criteria for making what I call a “definite” or unqualified diagnosis are present — i.e., a compatible clinical picture and a confirmatory test — that is so much the better.

When the set of symptoms and physical findings do not form an immediately recognizable pattern, clinical reasoning theory tells us that we tend to move into a second more deliberate process of clinical reasoning — one that is slower, using not an aesthetic principle of pattern recognition, but rather the analytic process of hypothesis formation and confirmation. The purpose, in any case, is the same as pattern recognition — coming up with a single term that can, by means of a “label,” represent the complexity of the patient’s experience in a single term, such as community acquired pneumonia or diffuse toxic goiter.

The second thing I want to emphasize — the first was the relationship a physician has to understanding nature — is that giving a *name* or label to the underlying process provides several advantages to the process of trying to help the patient. First, we have a shorthand, or a label with which to synthesize the complex presentation of facts and findings into a single term. We know from both educational psychology and the development of expertise that this is one of the ways that expertise is developed and works. For instance, a chess master can play two dozen games simultaneously because he does not remember the details of his opponents’ moves, but rather assigns a label to each adversary’s chess board. This one is “Queen’s Gambit” or the “Sicilian Defense.” I have to confess that the habit of internists, for which we are often maligned, of referring to the “diabetic in room 321” is, in fact, a very effective tool that helps us follow 10 different sick patients on a ward team.

The second advantage of labeling the patient with a “diagnosis” is reassurance and comfort. I can reassure myself and the patient that I understand their problem and can help them. This comes from the age old sense that the prerogative to name something is a type of power. Think of Adam in the *Book of Genesis* naming what he sees. The third advantage of naming the problem is that if we have some degree of certitude or knowledge in what the patient has — that the label is justified by meeting agreed-upon criteria for diagnosis — then we have met the classical definition of knowledge as justified, true belief. We can use this label as a lever to search for help in our care of the patient. If our own experience and knowledge are not enough to help the patient, then we can use or adapt the experience of experts published in textbooks and journals. In order to access others’ expertise we need

a name, a label, a diagnosis that allows us to use the index in a book or enter a search term in an online resource.

Suppose we are not sure whether a condition needs to be treated or what to expect from the usual therapy. Prognosis is to know in advance. Diagnosis precedes prognosis. The diagnosis allows us to move to some prediction about what will happen to the patient if we do nothing. That is because we cannot do this based on our description or our documentation of the many clinical findings in front of us. Without a label, without a diagnosis, we cannot access prior knowledge in our own memory banks or in a textbook about the natural history. The shift from diagnosis to prognosis moves the discussion from clinical reasoning to clinical decision-making. This is where the analytic and intellectual approach in making a diagnosis really shows its limits because we are moving from a phase of understanding to one of action.

How do we think about the transition from understanding into action that requires us to get beyond the denotation of the specific diagnostic label? The process of reducing the complexity of the patient's experience to a single label happens here. The word reduction is in a pejorative context and means that the diagnostic label is a term of convenience. It allows rapid communication within our own heads, with others, and with patients. But it has limits.

Practically speaking, what do we teach students about the diagnostic process? In the last two decades, in most medical schools, skill in developing interpersonal communications and interviewing are introduced in the curriculum from the beginning of the first year. They are presented as a professional responsibility and duty, well before students have knowledge of diseases, or even physiology, that allow thorough diagnostic reasoning. In other words, respect for the patient as an individual, respect for their privacy, and developing a sense of trust are introduced within the first week or two of medical school. It certainly is in our own medical school right now. It was not that way when I was in medical school decades ago. At that time these principles were introduced in the second year just before we got to the clerkships. In the current curriculum the emphasis on conversation with patients, respect for what they experience, and allowing time for their story or narrative is gradually increasing. We all know this has not yet caught on with the billing metrics of an executive culture which still values procedures above conversation. I do not have time to explore that with you today.

The conversation with the patient, which we refer to as the interview in most medical schools, is central to this part of my discussion. What is its role in making a diagnosis? What is its role in formulating a plan of action? As we all know, or learned, the interview is a two-way street. We learn about the patient and they learn about us. The "us" could be me, personally. Do I listen carefully? Am I looking at my watch? The "us" also could be the patient's

team of doctors and the medical profession in general. What do we learn about patients? What they are experiencing? What symptoms do they have and who are they? What do they learn about us? Patients infer a great deal about what we are thinking and what they can expect to happen to them. By guesswork and inference patients also learn what diagnosis we think they might have and what might happen to them. They sense things about us as people and about our medical system.

How does information flow from the patient to physicians? These are the facts that get incorporated, often selectively, into making a diagnosis. This leads to my own recommendation for how structuring the history may help us get *beyond the diagnosis*. When the patient first comes to see us, there is an unspoken, immediate question: how sick is this patient and is this the right setting for us to help them? For the purpose of this discussion we will assume there is nothing life-threatening happening right now.

Shortly after gathering the initial description of the patient's story, what I will call the first paragraph of the HPI, we ask ourselves if this patient has a diagnosis yet. In other words — is this a problem in search of the diagnosis or an established diagnosis in search of the treatment? This first question is a diagnostic issue and is primarily cognitive. It is a question of clinical reasoning. The second question is a therapeutic issue, which is action. Actions require decisions about possible benefit, risk, and cost; the decisions are choices, and choices involve the values of those who are involved in making the decision. In other words, action is as much ethical as it is cognitive.

[A slide was shown depicting two circles labeled left and right to display how information flows toward the patient. The circle on the left embraced “what” the patient had. The circle on the right embraced “who” the patient was.]

The two circles combine into an interpretation and, if possible, a diagnosis. The circle on the left reflects our attempt to fit the symptoms and physical findings into a pattern that makes a diagnosis definite enough to allow some preliminary decisions about action, or at least suggestive enough to remain on our list of possibilities, which we call the “differential diagnosis.” If we have sufficient information from the patient we may even be able to “lock-in” a definite diagnosis, so we would not need to qualify it with an adjective, such as *probable* pneumonia or *presumptive* pulmonary embolism, to reflect our degree of certainty.

Who is the patient? When we first see a patient, experienced clinicians in internal medicine know that observations about symptoms, physical findings, and labs alone are typically not sufficient to achieve high probability, much less certainty, in a diagnosis. We need the context for making our observations. This is demographics and part of “who” the patient is, and it includes their age, race, gender or sexual identity, socioeconomic class, workplace, and environment, etc. We all know that chest pain in a 22-year-old has

a different set of probable diagnoses than chest pain in a 72-year-old. On one hand this Bayesian approach, using pretest likelihood, has proven to be a powerful tool that clinicians use to formulate their initial thoughts about what the diagnosis or diagnostic possibilities might be. On the other hand, it can lead to cognitive biases and even wrong conclusions.

Our group published a study 20 years ago in which a 45-year-old woman presented with palpitations and atypical chest pain. A videotape was shown to clinicians of an actress portraying these symptoms. When the actress was dressed in a business suit with an attaché case, she was invariably worked up for cardiac problems. If the actress was dressed in a red dress with elaborate jewelry and displayed in a histrionic manner, she was not.

I want to look deeper for a moment at the right circle mentioned earlier that represents “who” the patient is. Everyone agrees that this circle includes demographics and the social and medical context that I discussed earlier. Basic teaching always taught us that this information belongs in the “review of systems” that follows the initial attempt to convert the patient’s symptoms into a list of possible diagnoses. My question for you today is, when this is taught in your medical school, does “who” the patient is mean demographics alone or could it include some initial exploration of their own wants and worries and the values they would like factored into decisions about their care? To the extent that the patient’s demographics affect our differential diagnosis we are still mainly in a cognitive process, including information necessary to make a diagnosis. We combine these considerations with our knowledge of physiology and pathophysiology to reach inferences about what is causing the patient’s symptoms. This cognitive process is a major focus of the pre-clerkship phase of our medical school curriculum.

In many medical schools the pre-clerkship phase takes place in the first two years. It is the first step in a movement from understanding into action. USU has pioneered this transition from understanding into action expressed as a movement from “reporter - interpreter” and then to “manager-educator.” In other words, it is a movement from gathering observations about a patient, to reflection, to actions. The actions are the diagnostic and therapeutic plans, and patient education. This is, of course, the shape of the scientific method of observation, reflection, and action that was described by Aristotle more than 2000 years ago. This is the same rhythm that underlies what we learn as medical students in the rhythm of the clinical write-up: the history, the physical assessment, and the plan. Observation, reflection, action is what we call the “rhythm of RIME” — Reporter, Interpreter, Manager, Educator.

Up to this point I have been trying to locate the task of making a diagnosis at the “reporter-interpreter” level, the level of understanding. Our goal is to get it right and to be as certain as possible. I will borrow some terminol-

ogy and jargon from the business world and the process of moving from observation or data into knowledge.

[A slide was shown illustrating Haeckel's hierarchy.]

On the bottom we make observations that lead us to given facts or data. We place these in the context in which they are found in order to decide which observations are facts with meaning, and in the process, we reach a level of information. Hopefully, later, we reach knowledge and wisdom. I will return in a minute to that point and Haeckel's hierarchy.

Is certitude possible? Sometimes in making a diagnosis we get pretty close. Most of the time I am very confident that a patient with typical symptoms of thyrotoxicosis in the setting of a diffuse goiter has Graves' disease, and I would be justified in calling this presumptively Graves' disease. If I had some confirmation of an autoimmune process such as positive antibodies or ophthalmopathy, I could drop the present qualifier "presumptive" and just write down Graves' disease on my problem list. We all get pretty good at this process. Given the fact that we choose intellectually bright students from medical school, the process of putting the pieces of the puzzle together, forming a diagnosis, and making a diagnosis is typically successful within the scope of one's own practice specialty. It is not a perfect process, but it typically works well, and with the help of diagnostic support in the medical record, such as the use of computers and IBM's Watson, it could get even better.

What about certainty in therapy, not in diagnosis but in actions? We have useful practice guidelines for treating Graves' disease from the American Thyroid Association. I am sure you have guidelines in your own specialties, but we know guidelines do not work for every patient. Our prognostic ability to predict the results of the therapy are only probabilities and approximations. On one hand we have expert textbook type of knowledge and cognitive reasoning that we are accomplished at testing on multiple-choice tests and written examinations. On the other hand, we have the application of that knowledge to the individual patient in an individual setting, in an individual time and place. This is the hard work of moving from understanding into action, and this is where I see the importance of the phrase in the title of today's Artiss Symposium, *Beyond the Diagnosis*. For me this is really "beyond the cognitive" and moves us into a world of shared decision-making in which values have to be explored, sometimes uncovered by ourselves and the patient in order to reach a correct action.

To summarize, we are moving from an area of confidence to one of uncertainty. Choices have to be made that involve the availability of resources and patient preferences in a setting that requires rapid action. When we move from the area of cognition and understanding into the ethical situation, we all know that cognition or our knowledge (*gnosis*) is necessary but not sufficient. There has to be a conversation about values.

A decade ago the Institute of Medicine called this shared decision-making, but most of us were taught this process in medical school without a formal name. Making choices in which we do everything can be expensive for society, and it can be expensive for the patient. Doing everything can even be risky, because the more you do the more uncertainty there is, and the more things can go wrong. I am arguing that, along with the ethical need to explicitly explore the patient's values and take them into consideration, there is a principle of economy of action. I think economy of action is more than a matter of safety and cost; it is a matter of skill and elegance in our profession, and it is essential for competence. We teach our students, "Embrace Complexity, Act with Simplicity."

Returning again to Haeckel's hierarchy we see that, as we move up from observations into knowledge, we may aspire to and even achieve some measure of certainty on which choices can be made. We can define wisdom in this context as making right choices, and to do this we have to move beyond the simply cognitive approach that brought us to the diagnosis.

In medical school curricula, when and how do students learn and practice that our profession requires a promise of wisdom and right actions? If the context of the first two years or what we call the pre-clerkship phase is simply one of understanding, can students really do this? This is an enduring effect of the Flexner model from the beginning of the last century. The focus for understanding was on the internal environment — anatomy, physiology, and microbiology. Only in the last decade or two has the focus embraced the world in which the patient lives — the environment external to the patient.

There has been a great call for integrating teaching basic science with clinical medicine. In medical schools we teach in small group discussions using clinical vignettes, typically, "paper cases" with clinical findings presented in written form, and using standardized patients. Our medical school, like most others, gives medical students some exposure to real patients early in the first year — such as our visit to the home of the family of a child with cystic fibrosis — but is this really more than show and tell? Can students ever learn to go *beyond the diagnosis* in our present medical school curricula? Could students in the first year of medical school be given real responsibility as reporters, listening to the patient's story and documenting their experiences?

Toward the beginning of medical school perhaps students could work with amputees when they are examining the lower extremity of the standardized patient on their two month musculo-skeletal module. Later on, in the first year, during the neuropsychiatric module when students are studying the anatomy of the brain, and learning to do a mini mental status examination on standardized patients, could they also work with patients with traumatic brain injury? I do not mean that students would make diagnostic

and therapeutic decisions for these patients, but that their participation as reporters would be real. Students would be accountable, perhaps one-half day per week, to discuss and document how the patient was doing in the patient's own words. Students would obtain and record a patient's story reliably, with privacy, and without plagiarism. We have some educational jargon for this type of activity, "legitimate peripheral participation." This term was coined by Lave and Wenger to describe communities of practice, and how beginners start at the periphery of activity, doing real but noncritical tasks. The task is legitimate and the learners are accountable.

This is a dream of mine for the curriculum, and in the long run I think it is essential for curriculum design for practice in the middle of the century. I have no illusions about this. The curriculum is saturated, and it is difficult to get experienced teachers, especially like me who have been around a long time, to change the way they talk with patients and how they see the diagnostic process.

I would like to conclude with two concrete suggestions for those of you involved in teaching. They have worked well for me in internal medicine and in my own practice. First is to explore the patient's wants and worries and second is to "wash away the soap!" We all know that the classic HPI is generally accepted as the first major part of a patient encounter or history and physical, and it describes what appears to be the major problem for which the patient is seeking our help. I would like you to look at the HPI as a cognitive forcing structure, that is, something that is agreed upon by the teacher and student as a way to organize the data that will yield information, allow inferences, and eventually allow action. Basically I am arguing that the HPI include a paragraph that explicitly solicits and documents the patient's wants and worries.

[A slide was shown of a structured HPI.]

Paragraph 1 (P1) and paragraph 2 (P2) are generally accepted. P1 is the story of what the patient has experienced and describes their symptoms in detail. What makes symptoms better and what makes them worse? We could teach a law student or PhD student in biology to do this, since it is a matter of carefully listening and recording. Knowledge is required when there is a remote or prior part of the story involving interaction with the medical profession, diagnostic tests, and prior therapies. But for the most part P1 requires listening and recording skills. Paragraph 2 requires knowledge. This paragraph should include the pertinent positives and negatives that refine differential diagnoses. You have to know what the differential diagnosis is, therefore it requires knowledge to do this well. In our new medical school curriculum we teach this in the first year, since students study pharmacology, pathophysiology, and clinical reasoning in the neuropsychiatric module at the same time that they study anatomy and physiology. We introduce it

in the first year, and students become proficient by the end of the third year.

My focus today is the inclusion of a third paragraph, a P3, which would explicitly include the patient's concerns. What is their present understanding of their situation, what are they most afraid of, what do they see is the best outcome? What other factors are present in their life or family that are connected to this? Law students could also do this, if they had to. In other words the third paragraph does not depend so much on prior knowledge. It is a recognition of what is important. These three paragraphs also fit well with the "rhythm of RIME" — observation and reflection in preparation for action — so there is a naturalness and intuitiveness to it that *might* work. I say *might* because my own effort to get students to include patient's wants and worries often fails. The barrier also comes from faculty who feel that the patient's concerns do not belong in the HPI.

My second concrete point is a simple recommendation to WASH AWAY THE SOAP. This is a plea to discard the subjective-objective labels that Lawrence Weed introduced almost 50 years ago to help get consistent structure how we record and communicate patient information. I encourage you to use the more humane terms like stories and observations. This allows us to preserve the helpful mnemonic "soap." Symptoms and observations also works, but we prefer stories and observations.

I think we all know that in primary care and in the chronic care of patients, the symptoms are much more likely to yield a correct diagnosis in the so-called objective findings of the physical examination. It is really 80% as opposed to five or 10 percent. We also know that so-called objective tests like lymph node biopsies and mammograms yield a disagreement from pathologists and radiologists 10-20% of the time. In my own field of thyroid disease, pathologists disagree when reading thyroid aspiration cytology about 25% of the time, and when shown the same specimen several months later they often disagree with themselves.

My argument is not what the terms subjective and objective might mean in the field of epistemology, but what they imply for students who are trying to make a diagnosis. There is major confusion in the word "objective" with the word "certainty", just as there is confusion from using the word "certainty" in the context of "action." In our context of scientific medicine the term subjective for what is reported by the patient wrongly implies that the data are of lesser value, and that they might lead to incorrect inferences. The assumption of those who use the terms objective and subjective is that subjective information yields poor validity at the top of Haeckel's hierarchy. My argument to "wash away the soap" is both epistemological, and that it is demeaning to a patient's experience in their own story. It traps us in a world where, for many people, the word diagnosis equals knowledge and therefore certainty. We might even go further and ask, why should Medicare reim-

burse me for documenting the patient's symptoms and story if I characterize that information as subjective?

At the bottom of my exploration of the word diagnosis and how it fits into what we think we are trying to do as internists and physicians, are questions of who we are as physicians, how we are trying to understand human nature, and even when we exist as physicians. What I mean here is that our existence as physicians is contingent, depending on others' existence. Students will learn without teachers, but if one wants to be a teacher, one has to have students. Patients often get better without our help, or our help is not especially helpful, but if we wish to be physicians, we must have patients. From one point of view the teacher and physician have the knowledge, the power, and the authority, but from another point of view their existence as teachers and physicians is really contingent on the presence of another person. Physicians do not exist without patients.

Finally, to re-state the theme, if diagnosis really means a thorough understanding of the patient, an understanding of their nature, and of who they are, then physicians must understand nature. In one way, it does not get any deeper than diagnosis. It is a way of trying to understand who the patient is and what they have. What they experience in the limits of diagnosis are the limits of understanding and cognition. These are necessary, but not sufficient, and as we move into the world of action, making choices based on values, we are brought into a gray area without certainty of what the right answer is or the right outcome is. We only succeed if we have been actively seeking the understanding of who the patient is. This is the reason why I have suggested two simple concrete devices — the “third paragraph” of the history of present illness and “washing away the soap.”

Transgender Care: Beyond the Diagnosis and Defining Best Practices

Babette C. Glistler, MD

When endocrinologists ventured into the arena of transgender care in the military setting we recognized, along with many colleagues in and out of the military, that we had not done our homework. We needed to move in a totally new direction and in a very collaborative one to take the best care of the transgender population. My objectives are to review the most current consensus guidelines on best practice which have been developed fairly recently in endocrinology and review some of the history. I will define the underlying issues that need to be addressed to achieve best practice in and out of the U.S. military medical community and discuss the real life psychosocial challenges for health care providers and patients as we apply these guidelines in real life collaborations. Finally, I will define our future direction.

Dr. Wylie Hembree, from Columbia University, is an expert in transgender care and is very involved with the World Professional Association for Transgender Health (WPATH). In 2009, he advocated for the very first set of guidelines for the care of transgender or transsexual persons and put the guidelines under the auspices of The Endocrine Society, the largest society representing endocrinology in the world. Dr. Hembree will publish a revised set of guidelines soon which will have some interesting modifications describing different pathways of care rather than the traditional linear approach. Guidelines pool all available care data evidence and world expertise. Currently, a great deal of it is expert opinion and there is room for legitimate research. The Endocrine Society guidelines mirror the WPATH guidelines very closely.

Dr. Hembree defines dysphoria as a discomfort or distress that is caused by the discrepancy between a person's gender identity and the person's sex assigned at birth. The main purpose of treatment is to lessen dysphoria. In the early part of our treatment phases endocrinologists used a very linear approach. It was very step-wise and seemed logical to us to achieve the ultimate, final product of complete biological transition. Now we realize that the

treatment of transgender patients is much broader than that. The end points are very different for each individual and that makes collaborations between endocrinology and our colleagues in other disciplines very important.

The military will soon allow transgender servicemembers to serve very openly. We have had many meetings with various experts in the military, with endocrinologists, and other civilian medical experts who are helping guide our progress along this path. Dr. Harry Benjamin was one of the ground breakers in our community. Although he does not carry the label of endocrine or endocrinology he was, in his practice, truly an expert in sex hormones and one of the early endocrinologists in the 1920s. He was born in Germany but became a U.S. citizen and specialized in the recognition and the early treatment of transsexualism. Dr. Benjamin was a key figure in establishing WPATH. WPATH led the way in establishing best practice and effective care. Dr. Benjamin was a leader in the early research and was very influential in the Johns Hopkins Hospital clinic for gender dysphoria and sex disorders in the 1960s. The clinic was also one of the first big players in the surgical management of transgender patients.

What endocrinologists do very well and understand very well are the standard hormonal regimens for gender transformation. We use commonly available medications in different realms. The doses might be a little higher than for other indications, but, in general, the medications that we utilize are not complex. One of the questions that comes up often in the care of transgender patients is how long does it take for hormonal changes to occur? It is a fairly significant amount of time — up to two years. Sometimes patients have a sense of urgency and want to rush the process. This may create angst and worry in endocrinologists who care for transgender patients.

For a transition from female to male we schedule three month follow-up intervals, annual schedules, and very typical laboratory blood tests to measure testosterone, estradiol, lutenizing hormone, and follicle-stimulating hormone — all the usual labs. There are other things we watch for regarding liver toxicity and prolactin elevation. In general, bone density is not a big concern. The absolute risk of blood clots is not thought to be as high as we initially expected it might be. There is some long-term malignancy screening and other screening that we may not be doing as well as we should. Endocrinologists need to zero in on some of these things and hold the standard as far as quality care for the patients who do not always seek continued care.

Dr. Michael Irwig, from George Washington University, is considered one of the experts in transgender care. He recently published an article in *Endocrine Practice* under the auspices of our second largest organization, The American Association of Clinical Endocrinologists (AACE). Dr. Irwig's article reports on endocrinologists associated with AACE in the DC/VA/Maryland region who were surveyed anonymously. The group was com-

posed of 61 adult endocrinologists, 13 fellows, 2 pediatric endocrinology colleagues, and 4 nurse practitioners/physician assistants. The survey found that 20% were very comfortable discussing gender identity. Forty-one percent described themselves as, “somewhat to very competent” in transgender care. Twenty percent of endocrinologists desired more transgender patients, 14% desired fewer, and 67% had no preference. Less than a third of participants had seen more than five transgendered patients in their entire practice and only 16% were actively seeing that many or more. On the positive side, 59% almost always used the correct gender pronouns. On the negative side, over one-third of providers refused to care for transgendered patients in their practices.

The Veterans’ Health Administration has seen a huge increase in the number of patients who have come out as transgendered. The number of patients that we care for in the Veterans Administration (VA) system is increasing so the comfort level in this arena is also increasing. The VA is doing an impressive job of trying to educate and they are really moving forward with their agenda. In a 2010 survey, deans from the U.S. and Canada medical schools reported that only 30% have legitimate curriculum covering transgender care. This is of concern.

Why are providers slow to evolve? The hormone transition is not difficult to do but the psychosocial issues are more than a little intimidating. When you talk to providers alone, they share the things that they worry about. Legitimate concerns and misperceptions need to be addressed. Providers have not had the conversations and the support that they need to be as comfortable as they could be.

There is aggressive vocal advocacy in this arena. It is in the media everywhere. Anything that criticizes the transition is met with a great deal of negative feedback. Providers are often painted in a negative light even when they feel like they are being supportive. Patients can be inpatient with the process, or at least that is the perception, and they can be frustrated by the linear process that providers have become accustomed to. There are emotional and religious reservations about the rightness of the dramatic change that is occurring with the body.

Expert reports from the 60s and 70s from Johns Hopkins Hospital suggested a potential lack of long-term benefit in the functional and the psychiatric outcomes. Since then the results have been re-explored and further review shows that only 0.3% of patients regretted their surgical transformation. The need for psychiatric care was still very prominent, and probably has more to do with the stigma associated with living the lifestyle than with the treatment. Providers and patients need to feel adequately supported to move forward effectively.

Dr. Paul McHugh, a very prominent psychiatrist at Johns Hopkins, re-

cently stated that he was not in support of transition being a normal desire for patients and that the surgeries had not been successful. There have also been conflicting reports from the early research. We are still waiting for new research that confirms long-term improvement and functional outcomes after either hormonal transition or surgical transition. There are some early suggestions that this is going to work out. Some providers are waiting for the data to feel more comfortable and supported. Social stigma reduction and increased support resources have definitely been correlated to improved outcomes in other healthcare arenas similar to ours. There is certainly a great deal of support for moving forward with transgender care.

LGBT persons are more likely to report poor health, not have mammography, or proper screening for things like ovarian or cervical cancer, in spite of the documented incidents of these cancers. Being overweight or obese and disabled at a younger age is more common in this population. LGBT persons may also be psychologically distressed by legal bans on marriage, prohibitive hospital visitation policies, and by being excluded from transgender care in the private and public insurance plans. They are also more likely to seek illegal or unsafe treatment. The LGBT population experiences a great deal of marginalization, discrimination, social stigma, and rejection from their communities and families. This leads to anxiety, suicide, and substance and alcohol abuse. We recognize these things. The biggest barrier to treating transgender individuals is a lack of understanding and acceptance from the medical community. Education and empathy can facilitate transition and care of transgender patients.

Dr. Irwig's report emphasized the importance of the use of correct terminology, to highlight non-discrimination and anti-harassment policies, to advocate for public and private health benefits that would be comprehensive for transgender healthcare, to redefine the definition of family to be much more inclusive, and to allow patients to determine who should be their visitors. Other issues were civil rights for marriage of same sex couples, more training for transgender care in medical schools and residencies, and comments about blood donation.

The issue that I think endocrinologists struggle with most is bias within providers. The Institute of Medicine notes that bias, stereotyping, and prejudice on the part of healthcare providers plays a key role in many different healthcare disparities. Explicit prejudices are the ones that are consciously held, for example, having "transgender" under psychiatric disorders. Implicit bias, which I think is harder to talk about, is at a subconscious level and often in conflict with conscious personal belief. These are unintentional, unacknowledged preferences for one group over another. Humans base their perceptions of reality on experiences that are reinforced until they become automatic. This ability makes human decision making efficient and is an

evolutionary advantage. Reinforcement of social stereotypes comes into play with the transgender population.

The U.S. sub-populations who have experienced the greatest health disparities also suffer from some significant negative cultural stereotypes. Implicit bias among providers has a major impact on clinical decision making. This has been proven in many studies with African Americans, Hispanics, obese patients, the elderly, and female patient populations. The studies show providers can have very low explicit bias, but still have very high implicit bias that leads to less aggressive management of things like pain or even the diagnosis of an organic disorder over a psychiatric one. In many cases patients are aware of these implicit biases, whether the physician is aware or not. In one study, African American patients were less satisfied with physicians who had low explicit bias but high implicit bias against race. They rated the physicians as less warm, less friendly and team oriented, compared to doctors who acknowledged their biases. Negative perceptions definitely alter patient behavior. They reduce adherence for follow-up care, trust, and contribute to these disparities being perpetuated.

What do we do to mitigate biases? There are strategies that have been suggested such as increasing awareness of physicians' susceptibility and making physicians aware that they might be exhibiting patterns of biased behavior. A study of gender disparities in chronic obstructive pulmonary disease (COPD) showed an absence of gender differences when physicians were provided with more specific, individualized spirometer data for COPD versus making an asthma or psychiatric diagnosis which is more common in women versus men. This strategy prevents physicians from filling in partial information with stereotypes and assumptions.

In another study nurses were shown pictures of white and black patients with generic expressions of pain. When asked how much pain medicine they would recommend, they recommended significantly more pain medicine for the white versus the black patients. Nurses who were instructed to imagine how the patient felt, recommended equal amounts of pain medicine for both groups. It is interesting that we can have very subconscious differences in how we treat patients.

Does explicit bias exist? Yes, it definitely does. We need to acknowledge our religious upbringing, our interpretation of religious teachings, and how we come to terms with our evolution with care of certain populations. Perhaps we fear overshadowing other underserved populations that have less aggressive advocacy and media support like the obesity epidemic and diabetes.

There are studies that show patients have both legitimate and some bias concerns as well. Older LGBT patients' experiences in Ireland showed only one in three participants believed that healthcare professionals had suffi-

cient knowledge to care for their issues. Only 43% felt respected as an LGBT person by professionals. Although 26% had chosen not to reveal their status for fear of a negative response, there were also many positive encounters of coming out to the healthcare professionals that were relayed in the interviews. When patients were willing to trust, there were many positive experiences. We need to understand all of the interactions and dynamics between our two stances.

People are recognizing that interactions are not all targeted toward the doctor and the patient in a small intimate relationship. The entire organizational structure and context within the hospital, the insurance policy, and operation in which care occurs significantly influences the willingness and the ability of patients, as well as clinicians, to engage in shared decision making. Patterns of work flow, shortened appointments, the increased pace, and the physical layout of privacy can impact whether we discuss important issues and if we discuss them in a way that is effective.

We have had more research in recent years, but it is not nearly enough. Some providers lean on the data to feel comfortable with their decision making in this arena. We need a better understanding of the healthcare needs of the transgender community and the challenges they face in access to care. An interesting study showed there is a developmental process to transitioning that is similar to grieving and other multi-step processes where you have the pre-coming out, then the coming out — where you acknowledge to yourself and others and you take some risks, exploration, experimentation, intimacy, and finally identity integration. Understanding the dynamics that occur during transitioning can be useful to providers to help understand what phase a patient is in and how a patient might react to differences in feedback from providers.

It is also important to note that there are many different health care disciplines that need to be involved with transgender care. Other disciplines need to be comfortable and we are seeing that evolution occur today. For example, we now have publications from the OB/GYN community on the care of transgender patients. Urologists talk about sex reassignment and offer their perspectives on outcomes and long-term care and complexity. Transgender care is complex not just in the health arena, but also in the other tasks and priorities that are part of this kind of social transition.

Financial security and healthcare coverage is very important for transgender people. Often their work situation is unstable because of discrimination. My transgender patients have been interested in legal issues, like name change processes and changing their military ID cards. Medical healthcare and support is important for the patient for their families. Earlier we talked about the medical agenda but there are other issues like voice therapy, the eventual removal of an offending gonad, facial and body reconstruction

which involve plastic surgery, urology, and multi-steps from the top surgery to the bottom surgeries. Who is going to fund all of this? Who has the obligation and the proper expertise? How do we train colleagues to do this well?

The role of the endocrinologist is simple when you distill it down. We confirm the appropriate criteria are met for the diagnosis. We make sure there are no key exclusions like uncontrolled mental illness or serious comorbid conditions that would exclude patients from safely using hormones. We document persistent well-defined gender dysphoria and the capacity to make informed decisions. Endocrinologists assess and manage risks like we do in any medical condition and develop appropriate protocols for individual patients. We monitor and ensure appropriate progress. We assess long-term care and outcomes, which we are always refining to define, and endocrinologists continue to collaborate with other healthcare providers. This makes us better doctors so that we provide better care to our patients. Endocrinologists feel strongly that we need to be able to lean on some of our other colleagues to do this well.

Dr. Hembree pointed out a new concept — the non-linear approach to care — which is an informed consent model where patients may not have to go through three to six months of the real life experience and a multi-step process. Often many aspects of transition are happening at once. People have already thought it through, talked with their families, and have their support systems in place. I think one thing that was disconcerting to the endocrinologists, the internists and other primary care providers was Hembree's statement that providers prescribing hormones, or health professionals recommending them, should have the proper knowledge and experience to assess and care for gender dysphoria. To some extent we do that in other areas of endocrine practice and general medicine, but we feel a little bit uncomfortable with *completely* defining that these are well met descriptions of gender dysphoria and that we have managed the mental health concerns. It almost feels like endocrinologists are abandoned and forced to do this alone. It is as if the endocrinologist should be the only stop and the hormonal doctor has to be everything to the patient including providing the behavioral health component. Perhaps this is not true, but I think much of the discomfort in the endocrine community comes from feeling like the support that we need is often absent.

What are the risks to the patient? I think endocrinologists worry about risks more than the patients do. Early on it seems like transitioning is not that big of a deal. Internal medicine follows the entire spectrum of the life span and we want to make sure that what we are doing now is not harming our patients in the future. Cervical, vaginal, endometrial, and ovarian cancers are rare in transgender patients but they have been reported and

patients need to be monitored. Unfortunately, many patients feel that this type of monitoring is unnecessary. They may be emotionally distressed by doing the proper surveillance and avoid proper monitoring. Breast cancers are a concern since breast cancer has been found in residual mammary tissue after the breast has been removed.

There is interesting literature in press that may show an increased risk of cardiovascular disease in male to female transsexuals treated with estrogen. These patients show more pathology in the cardiovascular realm than female to males. Why this happens is still unclear but the mode of treatments might be partially involved. We need to understand this more completely.

Transdermal estrogens have decreased the risk of complications from estrogen therapy; however, many transgender patients are biased against transdermal approaches. They think that they are not as strong and not as effective as estrogen administered orally or by injection. Many patients have negative feelings about using what some doctors may feel is a safer transdermal approach. For example, the transdermal patch may be a better delivery system in an older patient who may be a cardiovascular risk. The total exposure to estradiol for males transitioning to female is much lower than what we normally prescribe in a birth control pill. We routinely deploy servicemembers on birth control pills and we do not think twice about it. Perhaps age makes a difference. A better understanding and a better delivery system to assess total dose exposures so we know what the absolute risk of things like venous thromboembolism (VTE) is in the transgender population would be helpful. Right now we only have anecdotal reports. We have no hard data. There is a great deal of discomfort that we need to explore in the physician community that may or may not be legitimate.

Other potential concerns include prolactinoma and liver toxicity of certain injectable preparations — concerns that take time for us to discuss with patients. I mentioned earlier that breast cancer can occur even after mastoplasty. Malignancies of the vagina and ovaries can also occur. Testosterone-aromatized estrogen may have an effect on the endometrium, if it is still in place. Urethral fistulas, strictures, stenosis, and other voiding issues can occur after other types of surgery.

To conclude, endocrinologists recognize that the hormone management is not the difficult part. Teaching medical trainees early and updating older healthcare providers who are likely to encounter transgender patients in their practice is important. Primary care must be one of the leaders in the movement forward. Primary care doctors are very likely to encounter patients who are requesting support and care, and asking for long-term management of their overall health. It is critical to establish a new norm and a comfort with evolving best practice with surgical specialties, and for all of us to collaborate on that initiative. Behavioral health and social work support,

as well as infrastructure with options for multi-dimensional collaboration will benefit providers as well as patients.

We need to reduce discomfort and stigma. New initiatives and priorities for eliminating these disparities and providing quality research for our future in transgender care will help to achieve long-term best practices that are desired by all of us. There is a new Transnet network that was started by Dr. Wylie Hembree, Dr Shalender Bhasin, and Dr. Joshua Safer. They are leading the way to create a resource, funded by NIH and other organizations that can promote new evidence-based literature on care for transgender patients.

Efforts are in motion to try to establish priorities for funds that might be set aside for research. In fact, Dr. Safer was recently invited to the Pentagon to consult with top leaders in the military to try to advance best practice in the services. We have a great opportunity if we do this well and there is a great deal of excitement. We want to have functional servicemembers who have the care that they deserve. We want everyone, from the provider down, to feel comfortable with how the process is evolving.

Beyond Diagnosis: A Psychodynamic Perspective on Treatment Resistant Depression

Eric M. Plakun, MD

Beyond diagnosis is something I will discuss in several ways. We will take a journey from molecular genetics, to epidemiology, to clinical research, and then talk about psychoanalysis. David Mintz and Barry Belnap, two of my colleagues at Austen Riggs, did a search of Medline citations over a recent 20-year period. They found that in that time frame there was an overall 25% increase in citations in psychiatry. In that same period, citations on the words “treatment resistance” had increased 800 percent. Something is going on in our recognition that the treatments that we use do not always seem to work.

Has anybody in the audience ever had a patient who did not get better? You are not listening if your hands are not up. There have been three books that have been published on this subject since 2011. We are having a problem with treatment resistance due to three false assumptions that I think we have made as a field that lead to an underestimation of the importance of psychosocial factors in the etiology and treatment of mental disorders. The three assumptions are: 1. that genes equal disease; 2. that patients present with single disorders that respond to single evidence-based treatments and; 3. that the best treatments are pills. I will discuss these assumptions one at a time. Since the human genome was decoded in 2003, there have been many genome wide association studies of numerous mental disorders. However, we are not finding single nucleotide polymorphisms associated with depression. There is one study of a group of Han Chinese people with severe melancholic depression finding some hint of one thing. But what is clear is that this is not simple Mendelian genetics. Whatever is going on is highly complex.

In depression and in disorders like schizophrenia there are almost 130 found putative single nucleotide polymorphisms (SNP). Most of them are reactive to the environment. It is not very clear what is going on. Even with the recent publicity about a variant of the C4 gene that increases synaptic

pruning — valuable research — it is important to notice that this only increases the ability to predict the presence of schizophrenia from 1 to 1.25 percent. This finding is not exactly night and day. We are dealing with something that has to do with very complex kinds of inheritance.

At the same time, although mental disorders are clearly inheritable, genetics has shifted to epigenetics. We are finding a great deal of evidence that is interesting. For example, maternal major depression during childrearing increases the risk of depression in adolescents regardless of whether the children are adopted or biological. It is a gene by environment world, not a genetic world.

I hope most of you are familiar with the study done in 2003 by Avshalom Caspi on the serotonin transporter promoter gene. It is not the gene for depression. It does not account for much of the variance but it is heuristically very important. Another study found that there are short and long alleles of the serotonin transporter promoter gene. If you have the short alleles, and homozygous short alleles, you appear to be more vulnerable to early adverse experiences like sexual abuse. You are more likely to become depressed in the face of adversity than if you have the long alleles. When you have the homozygous short alleles of the serotonin transporter promoter gene and you do not have adversity — that is if you have a “good enough” environment — you do better than anyone else. It is not a vulnerability gene, it is a plasticity gene. In our training we are taught to look at vulnerability. As Jay Belsky puts it, vulnerability genes may actually function more like plasticity genes, resulting in certain individuals being more responsive than others to both positive and negative environmental experiences.

I am suggesting that psychosocial treatments like psychotherapy are positive emotional experiences. And I think they have a beneficial effect in accessing resilience. We could talk a long time about plasticity versus vulnerability, but today we will not. Let me give you the “tomato” example to illustrate what I mean. If you go to your local McDonald's you will get a very industrialized tomato built on a vulnerability model. We need tomatoes to be a certain size. We need them to be a certain firmness. The tomatoes do not have to taste good. If you pay attention to the vulnerability, if you recognize that certain varieties are very sensitive to the right moisture, to the right temperature, to the right pests; they are going to grow in odd sizes and they are going to ripen at different rates. You wind up with the heirloom tomato that tastes much better than the fast food tomato. Paying attention to plasticity rather than only to vulnerability is worthwhile.

Some very interesting concepts are coming from translational research. Moshe Szyf from Montreal talks about separating monkeys from their mothers early in their childrearing and how this leads to massive methylation of the DNA in cells in all organs of the body. When DNA methylates it is

not just in the brain cells; it is kidney cells; it is liver cells; it is all kinds of cells including gametes, the eggs and the sperm. This is how the phenomenon of intergenerational transmission of trauma can actually occur. By switching genes on and off, the methylated genes are taken off the workbench and replaced by others. Szyf points out that demethylation occurs during social play with other monkeys. It also occurs during quiet periods of reappraisal when the methylated monkeys who were separated from their mothers are provided with a quiet space and some cue reminding them of their mother, like the scent of their mother on cloth. That is when the demethylation occurs. The monkeys are doing a kind of introspective group work.

I think there has been an evolution of the “genes equal disease” model that has moved us from a vulnerability model initially, an epigenetic vulnerability perspective, to a more complex notion of gene systems interacting with the environment to produce a disorder or an adaptation, which is an epigenetic plasticity perspective. Those of us who are psychotherapists might begin to think of ourselves as clinical epigeneticists. We are working on the genome, probably in ways that have to do with demethylation of methylated bits of DNA. Meanwhile, while all this important work — and all of it is important — has been searching for the genetic underpinnings of mental illness, we have been searching desperately for biomarkers. People have begun to call this something comparable to the search for the Holy Grail.

We are also learning from epidemiology that experiences of early adversity, like sexual abuse, double the risk of having one or more psychiatric or substance use disorders. Adverse experiences are also associated with increased medical disorders. Kenneth Kendler tells us that in female monozygotic twins, the abused twin has a higher risk for lifetime psychiatric and substance use disorders. Early adversity is a very bad thing that is associated with all kinds of disorders, medical and otherwise. And one might wonder whether it is an enviromarker, even while we are searching for a biomarker.

The second false assumption that I mentioned, and it is certainly related to the topic of going *beyond the diagnosis*, is our wish to believe that patients present with single disorders that respond to specific evidence-based treatments. How do we know that is how it is supposed to be? What is the evidence? For example, if we look at bipolar disorder in the Systemic Treatment Enhancement Program for Bipolar Disorder (STEPBD) study, only 58% of patients recovered from the index mood episode within six months. Half of the patients had a recurrence within two years. There is more going on in bipolar disorder than simply a mood stabilizer deficiency. If you replace the deficiency people still have a great deal of trouble.

In major depressive disorder, the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study and numerous others, show that many

patients with depression fail to respond to the initial treatment, and switch to augmentation strategies, including cognitive behavioral therapy (CBT). Fava Wisniewski conducted a very interesting re-analysis of the STAR*D study and found that 78% of the people in the STAR*D sample — people who were naturally presenting patients — had comorbidities that would have excluded them from randomized trials. Among the comorbid patients, 78% were more intolerant of medications and they had lower rates of treatment response compared to patients without comorbidities (39% versus 52%) and lower remission rates from depressive symptoms (25% to 34%).

If you are like many of the people I talk to, they sometimes say, “I know this drug is supposed to work but my patients must be sicker than the ones they developed it on.” You are right four times out of five. When patients come to us, we cannot screen out the comorbidities and other disorders.

That changes the notion that patients have single disorders. That is not how patients actually present. The Collaborative Longitudinal Personality Disorder Study (CLPS) shows us some interesting things about the personality disorder diagnosis. The personality disorders adversely affect major depressive disorder outcome, cause persistent functional impairment, extensive treatment utilization, and carry significant suicide risk. In fact, personality disorders, especially borderline personality disorder, robustly predicted the persistence of major depressive disorder. One of the study's conclusions said you must assess personality disorders in patients with major depressive disorder. When I was in training we were taught that if you treated the major depressive disorder, the personality disorder would improve; but that is not shown by the data. The presence of the personality disorder looks like it makes the major depressive disorder treatment resistant.

Who would like to guess the most frequently diagnosed personality disorder under the DSM-IV?

PARTICIPANT: NOS.

PARTICIPANT: Avoidance.

DR. PLAKUN: Avoidance. NOS and avoidance. It was deferred. This is a big problem. If we have evidence that personality disorders adversely affect the outcome and robustly predict the persistence of major depressive disorders, and we do not want to think about the presence of personality disorders, and that is when at least you had a DSM IV prompt, please consider an ACT disorder.

This is perhaps the single most important question I have for today's topic. What is psychiatric diagnosis? It looks like patients have many different disorders. People who come to Austen Riggs have, on average, six different disorders. Have you ever noticed that we use the same 75 medications for everything? Sometimes you start with these, sometimes you start with those, but we use the same medications for everything. Patients, whether you look

at them cross-sectionally or longitudinally, often have multiple kinds of diagnoses. Caspi, our friend who did the research on the serotonin transporter promoter genes, noticed this as well. How many times have we heard “dorso-lateral prefrontal cortex” and “shrunken hyperactive amygdale?” Each time we hear this, it is as if it was a new neural anatomy of mental disorders. It is the same stuff — a little twisted insula here, a little ventral tegmentum there — but it is the same thing. And Caspi noticed this.

Caspi did something interesting. He looked at a sample of 1,000 patients in New Zealand whose symptoms had been followed for 20 years. He had a specific hypothesis. He said, “I think there are really only three disorders. I think there are externalizing disorders like alcoholism. I think there are internalizing disorders like anxiety. And I think there are thought disorders.” I think he lumped together obsessive-compulsive disorder and thought disorders. Run the factor analysis and we find there was some evidence that there were these three particular disorders that accounted for everything. Caspi said, “That’s good but it’s not that robust.” He conducted post hoc analyses to tell us how many different kinds of diagnoses there are when you run all the symptoms in 1,000 people for 20 years. The answer was one factor. I do not think Caspi was very good at naming, but he called it “P.” He talks about “P” as being comparable to IQ. If you have a high IQ there is a high likelihood you will do well with any cognitive task. If you have a low IQ there is a high likelihood you will do poorly with any cognitive task. With a high “P” there is a good likelihood you will have numerous disorders. With a low “P” there is a good likelihood you will not have any disorders. “P” turns out to be a function in adult adversity, family history, developmental history, and compromised early life brain function. It really suggests there is just one disorder.

I am going to say another piece about this. We live on the surface of the Earth, so when we look at the Alps we say that characteristic shape over there is the Matterhorn. That one is the Jungfrau. That one is the Eiger. We cannot see the plate tectonics underground that pushed the Earth up and created the mountain range. The same thing is happening in diagnosis. I think we see depression, and we see schizoaffective disorder, and we see post traumatic stress disorder (PTSD). We tend to name them like naming the mountains. What we cannot see are the plate tectonics and when we look for the thing that pushed up and made the Matterhorn, the genetic underpinning of the Matterhorn of depression, we find nothing. An entire plate of the Earth pushed upward and things happened to fracture out where they fractured. We recognize the Matterhorn and it is useful to us, but it is not telling us what happened underground.

The third false assumption I suggested was that the best treatments are pills. What do we know? We know that we have overestimated the efficacy of medication. When we do randomized trials we wind up excluding so many

patients that the drug works for a minority of patient studies. That does not mean pills do not work because they do. But whom you intended to treat may be different from who actually benefitted. We have overestimated the efficacy of antidepressants by about a third when we look at the unpublished negative studies. We are learning that 75% of the antidepressant effect is placebo effect. This is not only true of antidepressants. The Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study shows the same kinds of things in schizophrenia, where patients do not find the benefit of our medications are worth their side effects.

What do we know about what works? I am grateful to David Spiegel for citing Charles Nemeroff's paper about the patients with chronic major depressive disorder who have trauma history, and noting that those patients with the trauma history and chronic depression did better with therapy alone than with medication alone. The combination of therapy and medication was only marginally superior to therapy alone. Similarly, a paper by Falk Leichsenring and Sven Rabung found that the average patient with complex depression receiving long-term psychodynamic psychotherapy did better than 96% of patients receiving other shorter term treatments. Both long-term psychodynamic psychotherapy and cognitive behavioral therapy have been shown to be effective with treatment-resistant depression.

We know some things about what works. When it comes to the problem of treatment resistance and mood disorders there are a number of factors that we can identify that are leading to it — not every case — but in many cases. The combination of early adversity, of comorbidity of two kinds: general Axis I so-called comorbidity, but also explicitly and importantly, personality disorders. If there is reason to think that psychodynamic treatments may work and I think there is because they engage character pathology and immature defenses that are typical of personality disorders. That may lead us to want to pay attention to psychodynamic treatment.

I looked at a sample of 230 patients at Austen Riggs, which I think of as a national referral center for treatment-resistant patients. Austen Riggs is unusual. It is very different from what you are used to. Our average length of stay is five to six months and the minimum stay is six weeks. People undergo intensive psychoanalytic psychotherapy four times a week with a doctor on the staff. Yet, Austen Riggs is a completely open setting where patients come and go with complete freedom. In the sample I looked at almost 80% of the subjects had treatment-resistant major depressive order, and almost 90% had comorbid personality disorders. They were a self-destructive, suicidal group who had significant experiences of previous hospitalization and early deprivation and abuse. David Spiegel told us earlier that the more trauma and adversity you have had in your life, the more disorders of all kinds you will have. Trauma and adversity are not just associated with PTSD, as you know.

We followed these patients and found that overall about 80% were able to work full-time at follow-up compared to only 2% at admission. Eighty percent reported substantial improvement in quality of life. Among the half who had struggled significantly with suicide, 75% were free of suicide as an issue in their lives at an average of seven years of follow-up. This is not remission, it is recovery. It is the same kind of mathematical modeling that is used in cancer research. Patients really seem to be free of suicide as an issue in their lives.

I want to talk about a psychodynamic approach for complex patients like this to go *beyond the diagnosis*, to go beyond trying to target one diagnosis with one treatment and take a psychodynamic perspective on that. Of course, this is oversimplified but that is the kind of guy I am. I will talk about a psychodynamic perspective as translating behavior and symptoms into words.

Patients reveal to us in their character, in the evolving transference, in their symptoms, and in their encoded, non-verbal behavioral communications. Our task as psychodynamic therapists and clinicians is to help them break the code and translate their non-verbal communications into words so they can acknowledge them, bear them, and put them into perspective. Here is a quote from a guy whose name begins with F but it is not Freud, it is Faulkner: “The past is never dead. It’s not even past.”

I will illustrate 10 different principles working with patients like I took from the sample of patients discussed earlier. I derived them myself from reviewing all the cases. Afterwards, I took them to a consensus panel of my experienced peers and we derived a set of 10 principles that we could agree upon. An expert consensus panel is not very evidence-based. Should we take expert consensus seriously?

What about cardiology expert consensus and practice guidelines? The cardiovascular practice guidelines of the American College of Cardiology and the American Heart Association have 2,711 recommendations. Eleven percent are supported by the highest level of evidence: multiple randomized trials and meta-analysis. Forty-eight percent are based on expert consensus. Perhaps we do not want to turn our noses up too quickly on expert consensus in places where we do not have hard data.

To make the set of 10 principles more accessible I will illustrate them around a particular patient that I treated at Austen Riggs many years ago.

Principle 1: Consider a diagnostic comorbidity.

As I mentioned earlier, the patients at Austen Riggs in this sample had, on average, six Axis I and II disorders, using rigorous research-level diagnoses. Eighty-six percent had personality disorder comorbidity. Seventy percent had what we used to call dysthymia and is now called persistent depressive

disorder. Fully more than a third had PTSD. Forty-one percent had substance use disorder. There is a great deal going on.

How does this play out? I will present this by discussing the case of Ms. A. Ms. A. was a 43-year old widow who had a treatment-resistant bipolar 2 depression, multiple suicide attempts, and multiple hospitalizations. Since her husband's death four or five years earlier she had been depressed and erratic. She had mood instability that looked like hypo-manic episodes. Her outpatient treatment had become chronic crisis management. The referring doctor, sadly, was always recovering from the last hospitalization or fending off the next one. We call this chronic crisis management. No work could be done.

Ms. A. and her doctor talked. Recognizing that she needed something more, he made a referral to Austen Riggs. My job for a long time at Austen Riggs has been Director of Admissions, and I met with Ms. A. in that role. We conduct a two to three hour admission consultation face to face, which is the only place where I can assess whether the ice on the pond is thick enough to bear the weight of crossing it. I say that because these patients are not restricted in any way. Although they receive intensive psychotherapy, they are free to come and go.

We talked about her situation. I thought to myself this is not bipolar 2, this is a major depressive disorder with a borderline personality disorder. In fact, there are excellent studies showing that bipolar 2 disorder is often over diagnosed and that, in fact, the psychosocial burden of borderline personality disorder is comparable to, and in some ways worse than, bipolar disorder. Ms. A. also had so-called double depression, dysthymia, and delayed onset PTSD related to early childhood sexual abuse by her father.

Principle 2: Carefully negotiate and use the therapeutic alliance.

What do we mean by "therapeutic alliance?" It is not just the medical model of knowledgeable expert and passive patient. The alliance is the foundation that supports the entire treatment. It includes an agreement to explore the patient's mind and meaning. It is one of three parts of the therapeutic relationship. Two parts are always present. The transference relationship is always present. You meet with a patient and things from that patient's past will become their expectations of how you will behave. There is always a real relationship. No matter what happens, any patient who sits down with me is sitting with a bearded, overweight, balding guy. That is part of the real relationship and it is always there.

The therapeutic alliance is only there if you explicitly negotiate it. You must have a conversation about what its limits are, what you need and expect from the patient, and what the patient can expect from you. There are five building blocks that I think of around the therapeutic alliance. It is an inten-

tionally and explicitly negotiated agreement between patient and therapist to collaborate in a treatment task. It includes agreement to explore the patient's mind and meaning. It is a task to which they are each committed and subservient. So, in a sense there are not just the two of us in the room — the patient and myself — there is also the work that serves as a kind of third person. We are each committed to that work and subservient to it even when the going gets tough. We are committed in periods of regression and aggression. If we carefully negotiate and use the therapeutic alliance, if we have a strong attachment and a strong positive transference it can help contain acting out and keep it in the therapy.

Let me illustrate with Ms. A. We did the admission consultation. I made my assessment of her diagnosis. I realize the important contributions of a borderline personality disorder and of her early trauma history. She told me about the horrible story of her father, when she was about five, discovering that Mom was having an extramarital affair with his best friend. He drifted into alcoholism. In her father's drunken stupors at night he would sometimes come down the stairs to the basement where her room was and try to get into her room. She had one of those rooms with a push button door lock. If you had a screw driver on the other side and you could get it in the hole you could pop it and it would unlock. Sometimes he was sober enough to pop the lock; sometimes he was not. Sometimes he would enter the room and she could talk him into going back to bed. Sometimes she would be sexually molested and subjected to oral rape. She told me about this and it became part of an important narrative for her.

I decided the ice was probably thick enough to support the weight of this treatment. I said, "I'm prepared to offer you admission. You've worked hard with your insurance company to support your initial period of treatment. Your referring doc thinks it's a good idea. You think it's a good idea. I'm prepared to offer you admission." The expectation was that she would make the prepayment for the first six weeks of treatment — at that time it was about \$30,000 — which we already knew she could afford. The money came out of the life insurance proceeds that she received when her husband died. She said, "No, I'm not paying. In fact, Dr. Plakun, if you don't admit me without that I'll go home and kill myself."

It is white knuckle time. I am anxious. I am nervous but I know I have to hold the frame. I have spent a couple of hours with her at this point and I can say to myself, you know, she is in this pretty far. I mean she has really worked hard to get here, and I know she has the money. I said to her, "Look, I hear what you're saying, and it would be a shame to throw away this opportunity that you've really worked hard with your doctor and your insurance company to put together. And you're expecting reimbursement from your insurance company. So let me know if you change your mind."

Ms. A. stormed out of the office. I called her referring doctor immediately and said I did not have her committed. She did not say she was going to walk out of the office and throw herself into traffic. I was anxious, but I knew I had to show that I meant what I said, and I said what I meant about the frame. Ms. A. went home. A few days later she called back and said, "All right, when can I come? I'll make the prepayment."

Principle 3: Listen beneath the symptoms for recurring themes within the patient's life story.

Since treatment-resistant patients often involve people with personality disorders, and for this subset of cases treatment resistance involves their character structure, their immature defenses, and character is revealed in repeating patterns. These are the so-called therapeutic stories. We have been hearing about them this morning — the importance of a patient's narrative. What are the stories that begin to make sense of things? And we listen with a psychodynamic ear following the affect. It is very hard to do this properly if you are following a DSM checklist. You have this, this, this, this. You want to follow the story. Oh, that happened? Your father would come down the stairs. That sounds awful. Tell me more. You do not ask about sleep disturbance at that moment. You have to follow the act.

So how did this work out? I told you the beginning of the story with Ms. A. about being the first child of an idealized father who became an alcoholic and molested her. The molestation is an important therapeutic story. Here is another piece of the story. In spite of the molestation by Dad, he was the preferred parent. Ms. A. saw her mother as having no time for her and much more preoccupied with younger siblings. So her father was kind of kept off the hook, if you will.

A third story adds to the narrative: When Ms. A. was 5 or 6 years old she was doing something that she had been told not to do, which was to play near a cesspool that was being excavated for an addition that the family was building onto the house. It was winter and she was outside playing near the cesspool. She fell in the cesspool that was partially filled with very cold water. She was freezing. She tried to climb up the muddy bank in the wet snowfall and it was cold and crumbled under her fingers. She was getting very cold and she was afraid she was going to drown. There was a tree root just out of her reach and she did something that terrified her. She ducked her head under the water, terrifying herself, and leapt for that root. She was able to grab the root, hold on to it, and climb out of the cesspool. Her recollection of the story is she then runs into the house and tells her mother what happened. In her experience, rather than her mother being worried about her and how she nearly died, her mother was much more angry about her misbehavior and making a muddy mess of the kitchen and of her snowsuit. This is an

interesting therapeutic story for somebody who has fallen into the cesspool of treatment-resistant depression.

There is also the story of how Ms. A. left home. The molestation stopped when she was about 14 or 15 years old. It had gone on for nearly a decade but she put a stop to it with her father. When she was 17 years old she noticed something she never noticed before — a peephole in the wall of her room. Even though the molestation stopped, her father had been secretly spying on her while she was dressing and undressing. This was the last straw. What does she do? She does not leave the home. She does not report it to the police. She tried to speak to her mother once about this and her report was she got slapped and was told not to make up stories like that. What does she do? She becomes utterly impossible at home so that on her 18th birthday her parents throw her out. She lived her life, subsequently, as a child cast out of the family.

Principle 4: Practice psychodynamic psychopharmacology: Attend to the meaning of medication.

My colleague David Mintz has written a great deal about attending to the meaning of medication. I do not know whether you use the psychodynamic psychopharmacology approach when you teach residents about medications. With medications it is not only what to prescribe, but how to prescribe it. In a very oversimplified way there are three basic tenets of psychodynamic psychopharmacology. One is the “nocebo” effect. We like the placebo effect. Patients expect good things from beneficial healers, so we get a positive bounce from the drugs we are giving. The “nocebo” effect is the negative placebo effect.

What if someone had horrible experiences from early caretakers and what if they expect harm and not help from healing authorities? That particular punt down the field is not going to bounce in the direction you want it to. It is going to bounce back at you because it is a negative placebo effect, or the “nocebo” effect. This negative effect is a very important concept in working with people with early adversity. If anyone has a patient who tells you they tried half of a half of a pill and it still gave them side effects immediately, this is not about their cytochrome P450 metabolism. The medication did not even get to their abdomen yet. This is a meaning effect of medication.

There are two other kinds of treatment resistance: to medications and from medications. The question, when treating resistance to medications, is what will a patient lose if something works? I remember a case, not Ms. A., but another case of a woman who had horrific psychotic depression and hallucinated voices. No amount of medications helped. If you asked her what the voices were, they were voices of her dead child and the only child she had. She was a widow and her child was dead. If these medications worked

she would lose the voice of that child forever. It was not until the work of grief was done in her psychotherapy that she could begin to respond to medications. Treatment resistance to medications is based on meaning.

We also have treatment resistance from medications. I bet there are people in the room, I know I was one of them, who wound up compounding. The next thing you know a patient is on 12 medications. You are not sure any of them work and the patient is so sedated they can barely bring themselves to the session to do the work. That is an example of overprescribing out of counter transference, despair, and frustration.

How did this play out with Ms. A? She was quite intolerant of many medications. She was a “nocebo” responder with an exquisite sensitivity to side effects. I prescribed some amitriptyline, mostly for comorbid migraine headaches. She also took a small dose of risperidone for nighttime fears. She worried that someone would come in the window wherever she lived. She had flashback, and intrusive memories. Given Ms. A.’s history of oral rape, there were many struggles about who was in control of what went into her mouth. There were many struggles around medications until we could negotiate an alliance about this issue.

Principle 5: Attend to the transference and countertransference.

These are the mechanisms through which the patient’s life history comes to life in the room in the therapeutic relationship. I like what David Spiegel said this morning about the way that the transference is inevitably going to be to you, as an abuser. There is actually a triad of transferences available to you in working with traumatized patients: you can be the abuser in the transference; you can become the victim in the transference; and you can become the silent witness who knows about it and does nothing which is the kind of a role that Ms. A. saw her mother in.

How did this happen? Ms. A. she comes in and she sees she is assigned to me as her therapist and she says, “Oh, I am so lucky. Dr. Plakun, I just know you are going to fix me. This is just wonderful. I’m so happy. You sit at the right hand of God. It’s just wonderful.” What did I make of this in the contrast? First, I thought she was remarkably perceptive. But then I thought, you know, this does not feel good. The image that came to my mind was a butterfly collector. I felt like a prized Monarch butterfly pinned to a corkboard, worshiped, idealized, loved, and completely unable to do anything. I felt pinned. I did not say anything right away. I had to build an alliance first to try to contain things to get this to work. I would sometimes come away that I am imperfect and I would come late to the sessions. Ms. A. never said anything. I said, “Ms. A., did you notice I was late yesterday and today?” And she said, “Oh, Dr. Plakun, you are so good to me. I’m so lucky to be able to work with you.”

I noticed that I am off the hook. “What does that sound like, Ms. A? Kind of sounds like you and your Dad. We may want to pay attention to this and start to make points of the way people can be let off the hook even if they are leaving you in the lurch.” As in this relentless idealization, something is often missing in the overt presentation. What is being defended against? It is often an unconscious or unavailable action. Therapists whose patients did well were good at finding and putting into words the unavailable affects. It could be grief, rage, envy, shame; who knows what it is? But there was something more, for example, going on than simply idealization and love from Ms. A.

Remember that the first thing she said to me was if you do not do it my way I am going to kill myself. Right? So I knew there was more going on than that. And she would say, “I know you’re going to fix me.” I would say, “Well, you know, all I’ve got is kind of a root out.” I was punning on the root that she used to climb out of the cesspool. And in fact, we talked about the way she had fallen into the cesspool in her life now. You know, it was not much. I wanted to be there with her and be of use to her, but I could not rescue her. She was going to have to figure out how to climb out.

Principle 6: Find and put into words the unavailable affects.

Ms. A. became very angry at other people at Austen Riggs during the time she idealized me. I was wonderful, but the male social worker was an idiot. She hated him and thought he was useless. He was not doing anything that was of any use. I think in a system like Austen Riggs where you have a range of providers you have the ability to disperse the negative transferences, and then you gather them back up. I pointed out to Ms. A. that actually the social worker was an aspect of me.

I will never forget the day, about three months into the treatment, she figured it out. She said, “You know, Dr. Plakun, for someone who’s so brilliant, you are pretty fucking useless.” After that all kinds of angry assaults toward me took place. She started taking extra doses of the amitriptyline. I said, “I thought we had an agreement that I was going to be in charge of prescribing for you. And if we don’t have an agreement, we’re not going to be able to work together.” She wanted to invoke her constitutional right to buy a firearm. I said, “You do have a constitutional right to buy a firearm. I will not work with you if you make any steps in that direction.” The noisiest assault on the treatment was the day she stormed out of my office, angry at me for being useless, and she ran into the ladies’ room that is directly across the hall from my office. She began slamming the stall door. Bang, bang. “I want Plakun”. Bang, bang. “Send in Plakun.” I called the nursing staff and a nurse came over, stopped at my door and said, “Hey, did you want to go get her?” Thank you, Carol, “No.” Carol went in and brought her out. What I want you to notice is Ms. A. was replicating the boundary assaults of her outpatient

treatment. But this time, given the attachment, she was able to contain it and keep it within the transference relationship. It stayed in the treatment rather than destroying it.

Principle 7: Detect and use enactments.

What is an enactment? It is an ordinary English word but it has a specific meaning in psychoanalytic terminology. It is a mutual and complementary projective identification that is organized around life events from both participants. I like skiing as the metaphor. Enactment is a slippery slope but it is an inevitable therapeutic phenomenon that offers an opportunity to deepen the work. By the way, personality disorder patients who use immature defenses are very good at eliciting enactments and getting us.

Enactment is a slippery slope. As in skiing, sliding downhill on the slippery slope is not the problem. It is what you are there for. It is what you are supposed to do. But the difference between experienced and inexperienced skiers and therapists is how well they find and stay on their edges as they slide down the hill. That makes all the difference in the world between control and kissing a tree.

Here is an example of enactment with Ms. A. Joe Wise told you I was a primary care doctor in an earlier life. That has always been important to me. Once I had an inner ear infection with vertigo that terrified me. You know, a little knowledge is a dangerous thing. I decided I was having a stroke even though I was probably 30 years old. I called a friend who was a neurologist and he said, come on, it is a viral thing. It will be over in a day or two. Ms. A., in her wish to reach me, would often call and leave messages for me. She knew I would not get back to her. This is Riggs, and there are many people who will be in touch if there is some urgent reason. One day she left me a message that said, "Oh, Dr. Plakun, I can't come to the session today, the room is spinning, I'm dizzy, it's horrible. I'll come when I'm better." Without thinking, I picked up the phone and called her back. She answered. I say, "Ms. A." She says, "Dr. Plakun?" And I said, "Yeah. I called. You probably just have an inner ear infection and you'll be better in a couple of days and I'll see you then." And she said, "Dr. Plakun, you called." What am I doing? I am sliding down the ski slope out of control.

I consulted with a colleague and I figured out that I was getting quite attached to her. I really enjoyed working with her. She was a fun person. You can tell I still enjoy talking about her many years later. When she comes to the next session I do not tell her that I figured out I am fond of her. I listened to her chortling with delight: "Dr. Plakun, you called!" Dr. Boundaries is calling me. What, what? And as she spoke she said, "You know, there are many women here who have been sexually abused. And most of them really don't function very well sexually at all. I do. In fact, you know, when my father

molested me, I mean it didn't just ruin my life, it also saved my life. At least I knew one of my parents really cared about me."

That dialogue opened up a whole line of exploration for us about the way that the sexual abuse in her life also was associated with special status. There was something about that so-called Oedipal victory that was important for her. She was both furious when I would hold boundaries and delighted when I would hold boundaries.

Let me do a quick time out. Someone once heard me give this talk and thought that I was recommending sexual abuse. I am not. That is not the point. If you Google me on the internet, you will find somewhere down the chain a person who said, "Dr. Plakun recommends sexual abuse." I am not recommending sexual abuse. One of the reasons that sexual abuse is so damaging is partly because, in addition to its horrific effects, it can also be gratifying for people who feel otherwise forgotten and unclaimed.

Principle 8: Use interpretation.

Interpretation was used a great deal with Ms. A. There were initial linking interpretations to build the alliance. For example, you keep me off the hook the way you keep your father off the hook. We may want to pay attention to what that has to do with the story. Ms. A. used to call slowing down interactions the freeze frame game. We went back in slow motion and talked about things that happened between us. It is important to translate the encoded behavioral communications into words in order to show patients how they are caught in things that are out of their awareness and control. Often you will unravel them and begin to make sense of them. It offers patients an opportunity to remember and put things into perspective.

How was interpretation used with Ms. A? I talked about keeping me off the hook and the initial interpretation of the way her idealization of me was also a resistance. It was boxing me in and neutralizing me. Her own interpretation of the way that her sexual abuse ruined her life and saved it was probably the most important interpretation in the treatment. And Ms. A. made the interpretation. Her awareness of the wish to both recreate the abuse — Come on into the bathroom with me, Dr. Plakun — Bang, bang — but also her delight in my holding the boundary and not doing it was extremely important. Ms. A. was also able to begin to see her mother a bit more three dimensionally. Her mother had been kind of ignoring, but Ms. A. also actively pushed her mother away.

Over time we talked less about how depressed she was and how or what neurovegetative signs she had, and more about how sad she was about her life. What started out as a focus on major depression evolved into focus on grief and mourning. She thought she would escape with the man she had married, but then he died and she dropped into the cesspool again.

Principle 9: Implement a treatment plan that integrates treatment by all providers.

We work with treatment teams that use a psychodynamic formulation and we communicate with one another. I think the best example of this with Ms. A. was when Carol, the nurse, came to my office and said, “Hey, you want to go into the ladies’ room and get her?” Carol was not really serious. It was not a serious proposal. Carol was part of the treatment team. She knew this was somebody who had important boundary issues. Any kind of splitting in the treatment was averted by her simply understanding that and going in and taking the patient out.

Principle 10: Use psychotherapy consultation.

There are many roads to treatment impasse. We should turn to others for help when we feel stuck in a psychotherapy situation, as easily as we do when we ask someone about a different medication. I will tell you how this happened with Ms. A. It happened in the enactment when I told you about what I did when I returned her phone call. I turned to a colleague to help sort out why I had done that. It happened again around her termination. Her insurance company paid for a total of 15 months — six months in a higher level of care and nine months in a day treatment program. All of a sudden the insurance company refused more payments. Ms. A. said, “I’m leaving Friday.” I was bewildered. I had to turn to a colleague to help me make sense of this. My colleague helped me remember the way Ms. A. had left home. Remember when she found the pinhole in her bedroom? She uses someone else to get her to leave. As soon as the insurance company made the decision, it meant she could flee. It was a way of avoiding the attachment to me and mine to her. Once we talked about this she settled down and stayed another six weeks and we were able to do a proper termination.

In conclusion, I want to suggest that psychodynamic treatment is useful for a subset of patients with treatment-resistant mood disorders because character and immature defenses play a significant role. Psychodynamic treatment offers us an opportunity to remember to put into words and into perspective the things that our patients struggle with.

Speakers

Russell B. Carr, MD

Commander Russell Carr is Chief of Psychiatry at Walter Reed National Military Medical Center and Associate Professor of the Department of Psychiatry at the Uniformed Services University of the Health Sciences.

Commander Carr is a native of Tennessee and received his Bachelor of Arts degree with Highest Honors in Russian Language and Literature from the University of North Carolina at Chapel Hill in 1995. He then returned to Tennessee and received his Doctor of Medicine from the University of Tennessee at Memphis in 1999. He completed an internship in psychiatry in 2000 at Naval Medical Center Portsmouth, VA. Dr. Carr sought orders to the fleet and was transferred to USS SEATTLE (AOE-3) as the Medical Department Head and sole General Medical Officer on board from 2000-2002. During that tour, he deployed to the Persian Gulf with the JFK BATTLE GROUP in support of OPERATION ENDURING FREEDOM from January to August 2002. He then transferred to Branch Medical Clinic Gaeta, Italy, where he served as a General Medical Officer for three years.

In 2005, Dr. Carr entered residency in psychiatry at the National Capital Consortium in Washington, DC. In 2007, he was named a Laughlin Fellow of the American College of Psychiatrists, an award given to the top eight psychiatry residents in the country each year. He also began training in adult psychoanalysis, which is additional training beyond psychiatry residency done through civilian institutes. In June of 2008, Dr. Carr completed his residency in psychiatry. He then became a staff psychiatrist at the National Naval Medical Center Bethesda, MD.

In July 2008, Commander Carr deployed as an Individual Augmentee in support of OPERATION IRAQI FREEDOM for six months. He was assigned to the U. S. Army's 528th MEDICAL DETACHMENT, COMBAT STRESS CONTROL, which was already deployed to Mosul, Iraq. Dr. Carr served as a member of the unit's Prevention Team on FOB Q-WEST, Iraq, where he treated service members both on the base and on remote Combat Outposts. Upon his return to National Naval Medical Center, he served as the Medical Director of the Inpatient Psychiatric Ward. He was then selected to be the

Department Head of the medical center's Psychological Health and Traumatic Brain Injury (PH-TBI) Department, a position which also managed the hospital's PH-TBI funding, reporting to the National Capital Region's PH-TBI Coordinator.

In 2010, Dr. Carr was selected to be the Integrated Service Chief for the Adult Behavioral Health Clinics at both National Naval Medical Center and Walter Reed Army Medical Center. He oversaw the integration of these two clinics as part of the largest military medical integration in history. He was then selected to be Chief of Psychiatry at Walter Reed National Military Medical Center in 2013. In October 2015, the Psychiatry Department was realigned to the Acute and Outpatient Behavioral Health Product Line.

Dr. Carr is board certified in Psychiatry and is a Diplomate of the American Board of Psychiatry and Neurology. In 2013, he has graduated from psychoanalytic training at The Institute of Contemporary Psychotherapy and Psychoanalysis in Washington, DC, and has become one of two active duty military mental health providers who has completed training in psychoanalysis. He has published numerous peer-reviewed articles and book chapters on combat trauma and suicide, speaks nationally on these topics, and is sought internationally for consultation on difficult to treat combat-related PTSD.

Commander Carr is a qualified Surface Warfare Medical Department Officer. His personal awards include the Meritorious Service Medal; the Navy and Marine Corps Commendation Medal (2); the Army Achievement Medal as well as various unit awards.

Stephen J. Cozza, MD

Stephen J. Cozza, MD is Professor of Psychiatry at the Uniformed Services University where he serves as Associate Director, Center for the Study of Traumatic Stress. He is a graduate of the United States Military Academy at West Point, New York. He received his medical degree from the George Washington University School of Medicine and Health Sciences.

Dr. Cozza served 25 years in the U.S. Army Medical Corps prior to his retirement in 2006. Under his leadership, the Walter Reed Department of Psychiatry spearheaded the initiative to provide mental health services, support, and follow up to the combat-injured service members, their families, and their children who received medical treatment.

Dr. Cozza's academic and research interests have been in the areas of clinical and community response to trauma and the impact of deployment and combat injury, illness, and death on military service members, their families, and their children. He serves as principal investigator on several Department of Defense research grants that focus on these topics. Dr. Cozza is published in the scientific literature and has presented on these topics at

multiple national and international scientific meetings. Dr. Cozza serves as a scientific advisor to several national organizations that focus on the needs of military children and families.

Babette C. Glister, MD

Dr. Babette C. Glister, LTC, U.S. Army, is board-certified in Endocrinology and Metabolism as well as Internal Medicine, and is Associate Professor of Medicine at Uniformed Services University of the Health Sciences on the campus of the Walter Reed National Military Medical Center in Bethesda, MD.

Dr. Glister is a general clinical endocrinologist and medical educator with a particular interest in diabetes mellitus, bone metabolism, and women's health. Most recently, she has focused on resolving healthcare disparities in the U.S. Military with an emphasis on transgender care as well as the ongoing obesity epidemic. Dr. Glister lectures at local and regional hospitals and medical schools on osteoporosis, vitamin D deficiency, menopause, and the endocrine care of transgender patients. She has become a respected local authority on complex transgender care issues in the context of active duty military service, and remains an advocate for best practice in this arena.

Dr. Glister received her MD degree from the Uniformed Services University of the Health Sciences, after completing an undergraduate degree in Biology at the Johns Hopkins University. She completed her Internal Medicine internship at Tripler Army Medical Center, Oahu, HI. She then completed an Internal Medicine residency and Endocrinology and Metabolism Fellowship at Walter Reed Army Medical Center in Washington, DC. Over the past six years, Dr. Glister has been the program director of the only Army and Navy Endocrinology and Metabolism Fellowship training program in the U.S. military. During that time she also deployed honorably to Iraq as an internist.

Louis N. Pangaro, MD

Dr. Louis N. Pangaro is Professor and Chairman of the Department of Medicine at the Uniformed Services University (USU). He received his medical degree from Georgetown University in 1973, and completed a residency in Internal Medicine and a fellowship in Endocrinology at Georgetown and at Walter Reed Army Medical Center. He joined the Uniformed Services University in 1978. Since 2009, Dr. Pangaro has been one of the faculty leaders of curricular re-design for the USU School of Medicine.

Dr. Pangaro's scholarly work is in the evaluation of the competence of medical trainees, and he has published more than 100 articles relating to medical education. He created "standardized examinees" to calibrate the prototype clinical skills examination of the U.S. Medical Licensing Exam. He

created the RIME framework (reporter-interpreter-manger-educator) for defining expectations of students and residents. Dr. Pangaro has personally evaluated and given individual feedback to several thousand medical students, most of whom are still part of military medicine, and he has worked with more than a thousand faculty in teaching skills. He created a six-day course for military GME program directors in assessing competence, and nearly 300 program directors have participated in the last decade. Dr. Pangaro co-directs the annual Harvard Macy International Program for a Systems Approach to Assessment in the Health Sciences Education.

Dr. Pangaro has been honored by the AAMC with the Glaser Distinguished Teacher Award; by USU students with the Clements Awards for Excellence in Education; and by the USU Faculty with the inaugural Carol Johns Teaching Medal. He has been recognized by the NBME with its Edith J. Levitt Distinguished Service Award, and by CDIM with all three of their awards. Dr. Pangaro was named as a Master of the American College of Physicians (MACP), and in 2012 he received the lifetime achievement award from the Association of Program Directors in Internal Medicine.

Eric M. Plakun, MD

Eric M. Plakun, MD is the Associate Medical Director and Director of Biopsychosocial Advocacy of the Austen Riggs Center in Stockbridge, MA, and a member of its Senior Management Group. A board certified psychiatrist, psychoanalyst, researcher, and forensic psychiatrist, Dr. Plakun was on the clinical faculty of Harvard Medical School for more than 20 years. He is the editor of *New Perspectives on Narcissism* (American Psychiatric Press, 1990) and *Treatment Resistance and Patient Authority: The Austen Riggs Reader* (Norton Professional Books, 2011), and author of 50 published papers and book chapters on the diagnosis, treatment, longitudinal course, and outcome of patients with 1) borderline and other personality disorders, 2) suicidal and self-destructive behaviors, and 3) treatment resistant disorders. Dr. Plakun has presented more than 100 scientific papers at professional meetings around the nation and overseas. He is a Distinguished Life Fellow of the American Psychiatric Association, the leader of the APA Psychotherapy Caucus, past Chair of its Committee on Psychotherapy by Psychiatrists, and past chair of its Bylaws Committee. He is a Psychoanalytic Fellow of the American Academy of Psychoanalysis and Dynamic Psychiatry, where he is a former member of its Executive Council, and in 2004 was appointed Academy Representative to the APA Assembly. In the APA Assembly he is chair of the Assembly Committee of Representatives of Subspecialties and Sections, a member of the Assembly Executive Committee, and past chair of the Assembly Task Force on Psychotherapy by Psychiatrists. Dr. Plakun is a Fellow of the American College of Psychiatrists and past Chair of its

Ethics Committee, a Fellow of the American College of Psychoanalysts, and a member of the editorial board of *Psychodynamic Psychiatry*. He has also served with the American Board of Psychiatry and Neurology on the written test committee and as an oral examiner. He has appeared on the CBS show *60 Minutes*, where he was interviewed by Mike Wallace as an expert in forensic psychiatry. In 2003, Dr. Plakun was named by the 1,700 member Massachusetts Psychiatric Society as the “Outstanding Psychiatrist in Clinical Psychiatry.”

David Spiegel, MD

Dr. David Spiegel is Willson Professor and Associate Chair of Psychiatry & Behavioral Sciences, Director of the Center on Stress and Health, and Medical Director of the Center for Integrative Medicine at Stanford University School of Medicine. He has been a member of the academic faculty since 1975, and was Chair of the Faculty Senate from 2010-2011. Dr. Spiegel has 40 years of clinical and research experience studying psycho-oncology, stress and health, pain control, psychoneuroendocrinology, sleep, hypnosis, and conducting randomized clinical trials involving psychotherapy for cancer patients. He has published 12 books, 383 scientific journal articles, and 167 book chapters on hypnosis, psychosocial oncology, stress physiology, trauma, and psychotherapy.

Dr. Spiegel’s research has been supported by the National Institute of Mental Health, the National Cancer Institute, the National Institute on Aging, the National Center for Complementary and Integrative Health, the John D. and Catherine T. MacArthur Foundation, the Fetzer Institute, the Dana Foundation for Brain Sciences, and the Nathan S. Cummings Foundation. He was a member of the work groups on stressor and trauma-related disorders for the DSM-IV and DSM-5. Dr. Spiegel is Past President of the American College of Psychiatrists and the Society for Clinical and Experimental Hypnosis, and is a Member of the National Academy of Medicine.

Harold J. Wain, PhD

Dr. Harold Wain PhD, FAPM, is Chief of the Psychiatry Consultation Liaison Service at Walter Reed National Military Medical Center and Professor, Department of Psychiatry at the Uniformed Services University, Bethesda, Maryland. Dr Wain was Chief of the Psychiatry Consultation Liaison Service at Walter Reed Army Medical Center. He has previously been Director of the Psychiatry Consultation Liaison Service and the Director of the Psychosomatic Clinic. Dr. Wain has also been Chief of the Psychology Service at Walter Reed Army Medical Center.

Dr. Wain completed his clinical training at Walter Reed Army Medical Center. He has published and lectured extensively both nationally and in-

ternationally in the areas of psychosomatic medicine, hypnosis, somatoform spectrum disorders, trauma, pain, and consultation liaison psychiatry.



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